RECONNECTING THE SPIRITUALLY DISENFRANCHISED
MAKING ROOM AT THE KING'S TABLE

By

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Abstract

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This dissertation describes how residents of a nursing home and rehabilitation center were connected to a live, on-going, worship service. This was accomplished by using on-line video streaming. This project supports the mandated requirement that residents in these facilities be provided with continual spiritual opportunities and support. The scope of the dissertation will also explore issues concerning the disabled and the aged from biblical, theological, sociological, economic and political perspectives. The faces of the residents at the nursing home and rehabilitation center radiated with joy when they were reconnected to a worship experience. This project will be of value not only to those who find themselves in nursing homes and rehabilitation centers, but also those in our churches and other fellowships who are homebound as the result of disability or the aging process. This project makes the recommendation that the disabled, sick and shut-in, as well as the aged, should not be forgotten; but a continued effort should be made to reconnect them to their worshipping communities

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INTRODUCTION
THE JOURNEY BEGINS: THE CALL

It was a Sunday morning during the worship service as the choir began to sing I noticed that a member of the congregation was holding a cell phone high above the pew in front of her. It seems as if she was trying to record the singing of the choir. When I spoke to her after the service she informed me that she was trying to record the service for her shut-in, disabled husband who had not been able to attend church in months. She said it was her desire to reconnect him to the worship experience which he had missed since he has become incapacitated. As the result of this conversation and as the result of actually witnessing her effort, this experience gave birth to the subject of my demonstration project: reconnecting the sick, the shut-in, and the incapacitated to a worship experience by providing a live video streaming of a worship service.

As I traveled to my ministry at Silvercrest Nursing Home and Rehabilitation Center the next morning the image of this wife holding up the cell phone so that her disabled, shut-in husband could hear the service lingered with me. I wondered how many of the residents at Silvercrest experienced the same spiritual disconnection and isolation as this husband whose wife held up the cell phone so that he could hear the singing of the choir and as a result, be connected, to some degree, to the worship experience. This observation was confirmed by the therapeutic director who expressed the view that many of the residents experience this disconnection when they enter the nursing home. There have been studies that indicate that relatives of family members who live through the

eighth and ninth decade and who experience physical and cognitive losses must seek institutional care for them. It has been noted that often before admission to an institution the potential residents experience anxiety and some of whom express the desire to be reconnected to a religious fellowship. [1] Although the nursing home does provide regularly scheduled worship services, there is still a desire to experience a live worship service. The call had been given.

Silvercrest is a Nursing and Rehabilitation Center comfortably nestled in a residential area of Briarwood, Queens, N.Y. Its structure projects high above the low-lying private houses adjacent to it. However, it is a short distance from Hillside Avenue and Sutphin Boulevard, very active and busy commercial streets, brimming with fast food restaurants, banks, laundries, and drying cleaning stores, as well as judicial courts which serve the community.

Silvercrest opened for nursing and rehabilitation services in 1989 with a mission to create a continuum of care from hospital to community. It was sponsored by Booth Memorial Medical Center and the Salvation Army. It was originally named "Booth Silvercrest." The name Booth originated from the name of the founder of the Salvation Army, General William Booth, as well as the name of the Medical Center, Booth Memorial Medical Center. The name Silvercrest came from the crest of silver found on the uniform of members of the Salvation Army.[2]

Silvercrest is a 350 bed skilled nursing facility, a member of the New York Presbyterian Health Care System affiliated with Weil Cornell Medical College. The

[1] Sheldon S. Tobin and Morton A. Lieberman, *Last Home for the Aged* (San Francisco: Jossey-Bass, 1976), 17.

[2] "Silvercrest History," http://www.silvercrest.org/silvercrest_history.php (accessed January 17, 2016).

center provides service for those who are in need of long-term care, rehabilitation, ventilator and respiratory care, as well as those who would benefit from assisted living facilities. Silvercrest accepts patients 18 years and older. The median age of the population is 72 years of age.[3]

[3] Silvercrest Center, "Frequently Asked Questions," http://www.silvercrest.org/silvercrest_faq.php?page=3 (accessed January 17, 2016).

CHAPTER 1
THE TERRAIN: THE HISTORY OF NURSING HOMES

The history of Nursing Homes and Rehabilitation Centers reflected changing attitudes toward the care of the elderly and disabled. Throughout history society has always had to be concerned about the aged and the disabled. It was the concern of those in ancient Greece who worshipped the strong and the beautiful and described "Good is equal to beautiful and deformed or disabled is bad."[4] The early Roman society didn't have a word equivalent for disabled but used the word *monstrum* and regarded the birth of a disabled child as a misfortune. In the Middle Ages, Thomas Aquinas relegated or classified children, old people, women and slaves as part of the margins of society and this placed them in a lower social category or class.

In the 1700s the United States, as a young country, did not experience this problem of providing care for the elderly and the disabled due to the fact that the population consisted of mostly young people and the life expectancy was low. In addition there was a high death rate of children in infancy and childhood. Thus the percentage of persons living to old age was low. At this time the country was populated by Native Americans and immigrants many of whom came from England or other parts of Europe. Many immigrants decided to make the journey to the new country in order avoid persecution or simply to obtain a better quality of life. These immigrants were for the

[4] Catherine Shafer, "History of How We Treated People with Disabilities," http://www.catherineshafer.com/history.html (accessed January 19, 2016).

most part healthy young people because older persons simply could not endure the rigors of the journey. Those who made the attempt often died as they struggled to deal with the difficulties of trying to reach the new country.

The needs of the elderly and the disabled became evident in the United States in the 1800s. Before the 1800s less than five percent of the population lived in cities. The majority of the population was found in rural areas. Extended families provided the means of survival.[5] Life in rural areas had low economic requirements. These families were self-sufficient. Their communities were able to supply their own needs. They were basically self-employed. They were able to provide the basic staples for survival. They were able to create a community which provided for their medical care, physical safety and their education. They were self-sufficient. Those who reached an elderly age used their own financial resources to obtain care or they depended upon their families.[6] Those elderly who did not have families would be assigned surrogate families to care for them. Those who did not have families or surrogate families and had no financial resources were provided with care by charities or public welfare.

Public welfare was governed by what is known as poor laws which were pattern after the structure of the English Poor Laws. These laws provided public welfare for those who could not care for themselves. Often these facilities were located in remote areas. Those who provided care made living quarters as sparse and uncomfortable as possible. It was the concern of those who provided public assistance that the recipients were simply lazy and were individuals who simply did not want to provide for

[5] Ibid.

[6] Elder Web, "History of Long Term Care," http://www.elderweb.com/book/history-long-term-care (accessed March 18, 2016).

themselves. Most of these centers for their care were located on farms and the recipients were expected to provide the necessary labor on the farms to maintain them. They were further stigmatized by being forced to wear uniforms that identified them as welfare recipients.[7]

The public welfare system was not administered by the government. The care was provided locally by individual states. As a result the quality of the care would vary from state to state. Those who needed assistance were given cash payments known as outdoor relief which was paid for by the taxpayers of the city or county. This method of payment became too costly and the government decided to provide what became known as "indoor relief." They built poorhouses and almshouses to provide the services. Many of these facilities were owned by the government; others were state-owned facilities. Some states like Tennessee did not want to bear the cost of the welfare recipients and would actually sell the welfare recipients to the lowest bidder.[8]

These facilities became the forerunners of nursing homes in America they—cared for the incapacitated and for those who basically could not care for themselves. The first almshouse in this country was opened in Boston in 1660. It provided care for the elderly, disabled, mentally or physically impaired.[9] Often these individuals required shelter because they had experienced financial difficulty and as a result they were impoverished. Many of them had been abandoned by their families. Many had been displaced as a result of the Industrial Revolution and the Civil War. The population of the almshouse consisted not only of those who had fallen on hard times such as the elderly and the

[7] Ibid.

[8] Ibid.

[9] Shafer, "History of How We Treated People With Disabilities."

disabled but also orphaned children. The almshouses housed the neediest members of the community.[10]

However, at the beginning of the 19th century there were church groups and women's groups who identified with many of the occupants of almshouses because they were of the same religious and ethnic background. They took position that those with whom they identified with should not be housed with what they considered to be this needy element of society and they decided to establish homes for the aged. The Boston Home for Aged Women was established in 1850. The founder described the home as a haven for those who were "bone of our bone and flesh of our flesh."[11] Prior to the establishment of the Boston Home for Aged Women, in 1823 the Philadelphia Indigent Widowers' and Single Women's society established a home for the aged.

The motivation for improving the care of the elderly and the disabled was that the more worthy and disabled should not be force to live with the so-called unworthy residents of the almshouses.[12] The living conditions for the elderly and the disabled did not improve immediately throughout the nineteenth century. This concern was further emphasized by requiring entering residents to pay entrance fees and have certificates which identify them as being of good character.

The history of the modern nursing home has harsh beginnings, dating back to the nineteenth century almshouses and poorhouses that sheltered the destitute elderly. These institutions were places of both asylum and detention, housing a diverse population of the

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[10] Carole Haber, "Nursing Homes: History," *Encyclopedia of Aging*, 2002, http://www.encyclopedia.com/doc/1G2-3402200291.html (accessed December 26, 2015).

[11] Carole Haber and Brian Gratton, *Old Age and the Search for Security* (New York: Cambridge University Press, 1994), 130.

[12] Ibid.

poor, the chronically disabled, and the mentally ill. Mid-nineteenth-century morality tended to see poverty and disability, even in old age, as signs of an undisciplined, improvident, even profligate life. The harshness of the poorhouse and the social stigma attached to it were intended, therefore, to be socially therapeutic, prompting citizens to be provident for their old age and to avoid, at all costs, the bleak harbor of public dependency.[13]

In fact the proportion of poorhouse residents who were elderly increased from 33 percent to 66 percent. An additional xenophobic stigma was attached to the increase of the resident population, namely the influx of immigrant residents. There were those who resented the care given to immigrants or afforded to them. The almshouses still remained as the residence mainly for the impoverished. Those who managed the almshouse, superintendents and staff, regarded most of the inmates as unworthy and were destined to be long termed dependents on the state or public assistance. [14]

They were places of poverty, disgrace, loneliness, humiliation, abandonment and degradation.[15] Children were sent to orphanages; the disabled remained in hospitals; the mentally ill were sent to asylums. However, mental hospitals did not provide the most suitable atmosphere for those elderly residents who were suffering ailments as the result of aging such as various forms of dementia.

By 1923, 67 percent of the elderly were in almshouses. This prompted some locations to change the names of almshouses. New York City renamed their almshouses,

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[13] Bart Collopy, Philip Boyle, and Bruce Jennings, "New Directions in Nursing Home Ethics," *Hastings Center Report* 21, no. 2 (1991): 1.

[14] Ibid.

[15] Abraham Epstein, *The Challenge of the Age* (New York: Alfred A. Knopf, 1929), 218.

"Homes for the Aged." In North Carolina an almshouse became known as the Charleston Home. Despite the name changes the negative image of the almshouses stilled persisted.[16]

The Great Depression increased the need for the care of the aged and the disabled. It generated an increase in the population of those who required care. As the result of the rising number of elderly in the almshouses in the 1930s more attention was drawn to the need for the care for the aged and the disabled. The government took action. The Social Security Act was passed in 1935. The Social Security Act provided pensions for the aged. It was hoped that these pensions would make it possible for the elderly to live independently but it was discovered that many of the aged needed care and could not live on their own.[17] They required assistance. However, although social security pensions were not issued to residents of the almshouses it was necessary for residents to obtain care outside of public assistance. As a result occupants of almshouses began to move to privately owned facilities and this gave birth to the modern nursing home industry.

By the 1950s most almshouses had disappeared because they were unable to survive due to the fact that their residents no longer had financial support. Government funding for nursing homes continued to increase. Congress amended Social Security to allow residents in public nursing home facilities to receive federal support. In 1954, the Hill-Burton Act gave Federal grants to nursing homes which were built in connection with hospitals. Unfortunately this resulted in nursing homes which were modeled after

[16] Ibid.

[17] William C. Thomas, *Nursing Homes and Public Policy* (Ithaca, NY: Cornell University Press, 1969), 40.

hospitals. Oftentimes the nursing homes did not have a good reputation. There were those who referred to them as places where you "park and die."[18]

> Nursing homes can be frightening and depressing places. They remind us of our own mortality and of the inevitable time when most of us will face the frailty, ailments, and incapacities of old age. At the same time, nursing homes are places of refuge and respite; essential places to which exhausted families turn when they can't manage at home and when adequate community support is unavailable or unavailing. For some residents, too, moving to a nursing home represents escape from the loneliness, isolation, and danger of a solitary house or apartment. It means return to a social setting and a community of care and concern. Nursing homes are places to go home from—and many do. They can also be—and are—places people go home to.[19]

There was a continued effort to improve the image of nursing homes by increasing government funding. This effort eventually resulted in the Medicaid program in 1965 which now covers 40 percent of the cost of nursing home services. In addition, the character of the nursing home was influenced by the services provided by hospitals. Hospitals generally focus on short-term care, critical care and emergency care. Nursing homes began to provide service for primarily the elderly who needed long-term care. As a result at the end of 1950s and the beginning of 1960s there was a deinstitutionalization movement which was designed to identify nursing homes as specialized institutions whose principal service was to provide special care for the elderly who suffered from dementia and similar illnesses of the elderly.

In 1972 the Federal Government published specific requirements for nursing homes. Between 1960 and 1976, Medicare and Medicaid provided additional impetus to

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[18] Rincon del Rio, "The History of Nursing Homes: From Almshouses to Skilled Nursing," http://rincondelrio.com/info-for-seniors/the-history-of-nursing-homes-from-almshouses-to-skilled-nursing-2 (accessed January 19, 2016).

[19] Collopy, Boyle, and Jennings, 10.

the growth of the nursing home industry. The number of nursing homes grew rapidly. Between 1960 and 1975 the number of nursing homes in the United State increased by 140%.[20] In spite of their growth, there were concerns about insufficient and inadequate care for residents. There were accusations of financial misdeeds of those who administered the nursing home facilities. There was even questions of embezzlement and extortion of residents' assets and money from their families.[21] In spite of the changes which had been made the nursing home industry still carried the stigma of the poorhouse, almshouse culture, a place to put senile elderly.

In the 20th century there are now over 19,000 nursing homes in the United States, approximately 75% of them proprietary, 20 percent nonprofit and 5 percent government operated.[22] The cost of the care is provided by either Medicaid or Medicare. In 1965 Medicare and Medicaid were enacted as Title XVIII and Title XIX of the Social Security Act.[23] Medicaid pays for about 44 percent, Medicare covers less than 2 percent, private insurance pays about 1 percent and other government sources pays for the remainder.

Unfortunately, the Medicaid and Medicare methods of payment for nursing care at times create an opportunity for financial abuse.[24] Medicaid and Medicare payments or reimbursements are based on the concept of "fee-for-service" bases. The service which a nursing home provides determines the reimbursement money or funds. Frequently there

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[20] Rincon del Rio, "The History of Nursing Homes."

[21] Collopy, Boyle, and Jennings, 10.

[22] Ibid.

[23] Centers for Medicare and Medicaid Services, "Key Milestones in Medicare and Medicaid History, Selected Years 1965-2003," *Health Care Financing Review* 27, no. 2 (Winter 2005): 1-3.

[24] Jason Rodriquez, *Labors of Love Nursing Homes and the Structure of Care Work* (New York: New York University Press, 2014), 13.

is an interest on the part of the nursing home to increase the volume or frequently of treatment in order to increase the amount of reimbursement

Due to the fee for service method of reimbursement, nursing homes have become more focused on the quest for profits and not necessarily on residential care. This method of payment also encourages nursing homes to increase residential dependency. The more help a resident needs increases the volume of service which the nursing home is able to document and as a result increase the amount of their reimbursement.[25] However, now the CMS (Centers for Medicaid and Medicare Services) has imposed penalties on nursing homes when there is evidence of poor nursing care, such as infections and bedsores experienced by residents.

Nursing care for those residents who are only covered by Medicare carry a tremendous financial burden for them. Frequently their life savings and assets are consumed by the cost of the nursing home care. They are required to do what is known as a "spend down" to what is determined as a poverty level in a particular state, which then will make it possible for them to qualify for Medicaid. Often potential residents will transfer their assets to other members of their family to avoid this "spend down" requirement. The number of the elderly who must deal with these financial challenges is expected to increase. Currently there are about 2.3 million residents in nursing homes. These figures indicate that one in four who lives to the age of sixty five is expected to spend some time in a nursing home facility. In the next thirty years the number is expected to increase by 75 percent. As a the result of the continuous aging of our population the average age of the residents is eighty-four and will continues to increase

[25] Ibid., 14.

into the next century. The age of nursing home residents range from sixty-five to one hundred or older.

The pay for fee payment method has created a nursing care system in which more than two thirds of the nursing homes in the nation operate for profit and they are frequently a part of a chain of nursing home facilities. The management of these chains looks for opportunities by buying and establishing nursing home which frequently do not focus on providing the best care for the residents.

The long history of nursing homes not only has been driven not only by concern and interest in the care of the elderly and the disabled in our society, but also by practical necessity. Government pensions failed to recognize that some could not maintain themselves without help; and this resulted, ultimately, in institutional care of the elderly and the disabled and the emergence of nursing homes and rehabilitation centers

Relationships in Nursing Homes

In the course of the history of nursing homes there has evolved the need for understanding the relationships between residents, their care givers and family members. Frequently, caregivers and family members are unable to make changes in the care of residents due to an administrative approach known as "top down management.[26] This results in a sense of powerlessness.

As awareness of the effects of the nursing home environment has developed it has become the role of the social worker to help empower the family members and caretakers so that they can take a more active role in the care of the residents. This approach has been encouraged because there is recognition that caregivers and family members are

[26] Berit Ingersoll-Dayton, "Enhancing Relationships in Nursing Homes through Empowerment," *Social Work* 48, no. 3 (July 2003): 420-424.

most familiar with the needs and concerns of residents. It has been demonstrated that the role of the social workers can be of assistance in empowering the significant people such as family members, nurses' aides, and other caretakers involved in the life of the residents. This can be accomplished (1) by developing the individual strengths, (2) by helping the residents support group to recognize their potential to make a change, and (3) encouraging communication on an equal basis between the support group and so-called top-down hierarchy of a nursing home. [27] The social worker can help the members of the family and other support members of the resident to review the behavior and characteristics of a resident. This method of recall can often be of value to help members of the family and support groups to deal with emotions or issues which a resident might be experiencing. Efforts are made to increase communication between the family and caretakers and the administration of the nursing home. As the result of giving family members an opportunity to share information about the resident, this reduces the sense of isolation and powerlessness on the part of the family and caretakers and as a result develops a team spirit.[28]

Development of Cultural Change in Nursing Homes

Many regard nursing homes as frightening and depressing places.[29] When one enters a nursing home one's sense of independence becomes almost non-existent. As a resident, one is told when to eat, when to sleep, when to get up in the morning. One's sense of identity is diluted. One becomes institutionalized.

[27]Ibid.

[28] Ibid.

[29] Collopy, Boyle, and Jennings, 10.

As the history of nursing homes has evolved efforts are being made to change the atmosphere or what has come to be known as the nursing home culture.[30] Changing the culture would take the form of giving residents an opportunity to have a voice in their self-care. An effort would be made to create nursing home communities in which staff and residents would have an equal voice in nursing home management. The physical appearance of such communities would be quite different from what exists currently—quite unlike the massive towering structures which exist in many communities today. They would have the appearance of small cottage-like residential households. Their operation would center on giving opportunities to the residents to be in dialogue with management.

The culture change movement for nursing homes began in l997.[31] It was first proposed by an organization known as Nursing Home Pioneers, which later became known as the Pioneer Network. Their motto became change the culture when referring to the management of nursing homes. This was followed by the involvement of other nursing home associations such the American Association of Homes and Services and nursing homes in New England, such as Apple Health Care and Beverley Corporation. Two models for culture change in nursing homes were presented to the nursing home community. One model is known as the Eden Alternatives, which suggested that children, pets, and plants should be a part of the nursing home environment. Their presence would reduce the sense of isolation which many of the residents experience. The second model is referred to as the Wellspring Model, which is basically supporting the

[30] Anna N. Rahman and John F. Schnelle, "The Nursing Home Culture-change Movement: Recent Past, Present and Future Directions for Research," *The Gerontologist* 48, no. 2 (2008): 142-148.

[31] Ibid.

concept of developing an increased opportunity for interactions between those who are involved in the care-giving process.

The culture change concept continues to resonate in the nursing home care system. The conversations and various studies continue. [32] However, often when there is an attempt to change the status quo, there is opposition. There are those who reject the concept because it has not been thoroughly tested; and therefore, there is really no way to assess its value. There are those who are concerned about the additional cost of such a cultural change. However the conversation has begun and there is an awareness that there needs to be a review of the present culture of nursing home care and management.

[32] Ibid.

CHAPTER 2
ELDER CARE ACROSS CULTURAL LINES

The type of care for the elderly is often determined by cultural influences. Without a doubt, as human beings age impairments develop which require the need for health care intervention. Some impairments result in short-term illnesses or disabilities, others become chronic illnesses, and still others require long-term care. Cultures vary in terms of how they manage the health care requirements of the elderly.

Native Americans

The cultural attitudes toward the elderly influence how they are cared for in their society. The Native American/Indian population in America is composed of 569 tribes.[33] The elderly in their culture are respected and held in a place of honor by their families and their communities; and they are revered because they are regarded as the element in their society who will protect and help to maintain their heritage.

Native American families prefer to provide care for their elderly within their homes. It sometimes referred to as a desire to "age in place."[34] Their history teaches them the importance of an extended family and the need to provide for those who live a long life. However, due to poor economic conditions there are some elderly Native American

[33] Cynthia Printup-Harms, "Aging Elders Among the Native American Population," *NY Connects*, www.niagaraciunty.com (accessed March 30, 2016).

[34] Ibid.

Indians who must depend on outside sources for care because their family members must seek employment outside of the reservation.

Unfortunately, many of the elderly Native American Indians have been affected by what is known as anti-tribal policies which placed them on reservations and took away their territorial and sovereignty rights.[35] There has been an effort to improve the health care of the elderly Native American Indian by passing the Indian Health Care Improvement Act and Title VI of the Older Americans Acts 1976, but this has been unsuccessful because it fail to recognize their cultural practices as related to traditional healing ceremonies, medicines and their hesitancy about accepting western medical practices.[36] In addition, when elderly Native Americans go into nursing homes their tribal customs and beliefs are not recognized or respected.[37]

Health statistics involving Native American Indians indicate the elderly over the age of 65 years are probably suffering from high pressure, arthritis and diabetes. They experience the effects of social disability because of the oppression and repression created by colonization of North America by the Europeans.[38]

Managed health care is becoming available to elderly Native American Indians. However although the care is becoming available through Medicaid and Medicare it is difficult for them to access the care A major difficulty connected to obtaining service is

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[35] Lora A. Kaelber, "The Invisible Elder: The Plight of the Elder Native American," *Marquette Elder's Advisor* 3, no.1 (Summer 2001): 46-57.

[36] Ibid., 10.

[37] Ibid.

[38] Levanne R. Hendrix, "Affiliated Core Faculty Stanford Geriatric Education Center University of California Health and Health Care of American Indian and Alaska Native Elders," Ethnogeriatric Curriculum Module, University of California, San Francisco, October 2003, http://web.stanford.edu/group/ethnoger/americanindian.html (accessed March 30, 2016).

that often the hospitals and clinics are located at a considerable distance from the reservations and they have no means of transportation. Many times they feel that accepting help diminishes their sense of pride. Often they react to a sense that the assistance is given without respect for their cultural orientation.[39] In addition there is a basic distrust of the Western health care system which is fueled by historical abuse and the belief that the system is based upon greed.[40]

African Americans

The African American population in the United States is the result of the Diaspora created from West and Central Africa during the slave trade. In the 18th and 19th centuries, the effects of the Diaspora extended to the West Indies, South America, Central America and the United States.[41] The African American population is the result of the ethnic mixing of Africans with American Indians and European Americans in this country.[42]

African American elders are the fastest growing segment of the American population. By 2050 the elderly population of men and women over 65 years will be the largest population of all American ethnic groups.[43] Based on the 2000 Census, of the 36.4 million people, 12.9% are African Americans. New York is the state with the largest

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[39] Ibid.

[40] Ibid.

[41] Stanford Geriatric Education Center, "Health and Health Care of African American Elders," Ethnogeriatric Curriculum Module, http://web.stanford.edu/group/ethnoger/african.html (accessed March 23, 2016).

[42] Ibid.

[43] Melissa Welch, "Care of Blacks and African Americans," in JudyAnn Bigby, *Cross-Cultural Medicine*, ed. JudyAnn Bigby 29-60 (Philadelphia: American College of Physicians, 2003), https://store.acponline.org/ebizatpro/images/productimages/books/sample%20chapters/Cultural_Ch02.pdf (accessed March 30, 2016).

population of African Americans. However, more than half of African Americans live in the south.

African Americans have a deeply rooted respect for elders which originated in the African concept of the need for unity within the family and the community. The attitudes of African American are very supportive of their elders. The families tend to provide care for them at home, as opposed to nursing homes. Statistics show that African Americans resided in nursing homes at about half the rate of white elders.[44] However, in 1999 for the first time, the National Center for Health Care released data indicating that there were more African American elderly residents in nursing homes than white. African American elders are predisposed to certain illnesses such as hypertension, dementia, late stage renal disease, heart disease, cancer, stroke, diabetes and pneumonia. The causes of many of these chronic non-communicable diseases are attributed to a diet which is high in fat and salt. Characteristic meals of African Americans will consist of high fat foods such as macaroni and cheese, fried chicken and other foods which tend to contribute to chronic illnesses such as hypertension, diabetes and cardiovascular problems.[45]

The church plays a role in the care of the African American elderly. Often they provide nutritional programs, provide blood pressure monitoring services, subsidized meals, opportunities for community shopping and churches with the financial resources provide subsidized housing apartments.[46]

African Americans have access to government subsidized medical programs such as Medicaid and Medicare. Statistics show that in 2013, 34% of elderly African

[44] Ibid., 41.

[45] Ibid., 43.

[46] Ibid., 41.

American had both Medicare and private insurance coverage; 11% were covered by both Medicare and Medicaid.[47] Transportation to hospitals and centers of medical care are often provided by family members and church affiliations.

However, often there are some African American elderly who are intimidated by the health care system. Frequently, they described the health system as an experience that lowers their self-esteem. It is viewed as degrading. Many elderly African Americans are conscious of the effects of the imposition of a social disability due to the oppression which they have experienced. Health caregivers need to be sensitive to these concerns

It has been shown that caregiving in the African American family is provided with love and compassion. African Americans tend to reach out to their social circles to provide additional supportive care if necessary. They tend to set up a supportive network to care for the elderly members of the family.

Africa

In the land where the Diaspora began, in West and Central Africa, in Sub-Saharan Africa, an area south of the Sahara desert, traditional attitudes toward the elderly have changed.[48] In the past the elderly were held in high esteem and cared for within the family unit. Now the elderly are needed to take care of their grandchildren who have been orphaned and to care for children whose parents must work in order to provide income for the family. As a result the traditional ways of caring for the elderly in the family are

[47] Administration on Aging, "A Statistical Profile of Older African Americans Aged 65+," Administration for Community Living, U.S. Department of Health and Human Services, http://www.aoa.acl.gov/Aging_Statistics/minority_aging/Facts-on-Black-Elderly-plain_format.aspx (accessed March 30, 2016).

[48] World Assembly on Ageing II, "Difficult Situation of Africa and Countries in Conflict in support of Older People," United Nations, April 10, 2002, http://www.globalaging.org/waa2/articles/africa.htm (accessed March 30, 2016).

disappearing. At this point, the elderly lack financial support as the result of the changing family structure and unfavorable social and economic conditions which have resulted in their reduced ability to generate resources.

The elderly are becoming more vulnerable. It is being described as a crisis situation because in the view of many observers the old are being forgotten.[49] It is predicted by the year 2050 the number of the elderly over the age of sixty-five will increase from just fewer than fifty million to over 200 million. In Southern Africa, although the elderly are caring for their grandchildren, their basic health needs are not being met. They are not given opportunities to participate in development programs and they face discrimination when they attempt to get health care service.[50]

In spite of their contribution to society the elderly experience increasing poverty, violence, and abuse which prevents them from getting available entitlements. Many elderly live in rural areas where fewer services are available. Old age benefits do not exist. Almost two million elderly people are living in poverty in Tanzania. The women suffer most from this intense poverty. AIDS has attacked their families. In many situations they must take care of the children of their children, who have become victims of AIDS. They have a social disability due to age discrimination and changing roles and practices within the family. A survey of 15 African countries indicated that in 11 of these countries the proportion of elderly people living in poverty was higher than the national average.[51]

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[49] Global Health Aging, "Old and Forgotten: The Crisis of Africa's Elderly," Global Health Aging, August 15, 2014, http//global healthaging.org/2014/08/15/old-and-forgotten- the-crisis-of -africas-elderly-2 (accessed March 23, 2016).

[50] Ibid.

[51] Ibid.

The crisis of the African elderly is highlighted by the fact that Africa is considered to be a young country. Thirty-five per cent of its one billion population is between the ages of 15 and 35. And as a result more attention is focused on investing in the youth. The youth are viewed as that segment of the population which will bring about transformation in Africa. Nevertheless the facts indicate that the elderly are in need of help. The discussion continues to shift away from recognizing the needs of the elderly and the focus continues to focus on the needs of the children youth and women. An example of such programs is the Millennium Development Goals (MDGs).[52]

Advocates for elderly are encouraging efforts to partner with existing local hospitals and to train health care workers so that they may provide care for the elderly in homes in the form of health care assistance. The World Health Organization (WHO) suggests that health systems in Africa should adapt to the chronic care needs of the elderly as the shift to aging populations increases.[53] Advocates of the elderly have met with some success. In Angola in 2012, the Ministry of Welfare and Social Reintegration opened a home for the elderly. Even though it does not provide health care for the elderly, for those who have been abandoned by their families it will provide protection and psychosocial assistance. There is a project which has been introduce in Nshamba known as Kwa Wazee which brings some relief to the grandmothers who care for their grandchildren who have become orphaned as the result of the AIDS epidemic. This projects provides grants to the grandmothers in the form of pensions. They provide discussion groups which provide them with psychological, financial and social

[52] Ibid.

[53] Ibid.

information. The pensions improve the quality of life of the elderly grandmothers. The money which they receive from the pensions is used to buy food and clothing, as well as other necessary items. The improvement in nutrition makes it possible for the children to attend school. This organization has also been involved in creating a national debate focusing on the need to improve old age security. It is a beginning toward addressing the problem and meeting the needs of the elderly.

China

China consists of one-fifth of the world's population. It's political and geographic structure consist of thirty-two provinces, not including Hong Kong which is under their administrative control.[54] There are fifty-six ethnic groups, with Han being the largest ethnic group. Many of these groups have their own language, religion and lifestyle. The economic status ranges from the rich, multimillionaires in the cities to the very poor.in rural areas. The population is aging. By the year 2025 it is predicated that there will be 300 million Chinese who will be over sixty years old and by 2050 this number is expected to increase to 480 million, roughly a third of the current population. These demographics are expected to have an impact on the ability to provide care for the elderly.

The attitudes of the Chinese toward the elderly members of their family and community have always been supportive and respectful. Traditionally, families always provided care for their aging family members. Ancestor worship as well as their beliefs based on the teachings of Confucius provided the basis for their relationship with the

[54] J. Woo, T. Kwok, F.K.H. Sze and H.J. Yuan, "Aging in China: Health and Social Consequences and Responses," *International Journal of Epidemiology* 31, no. 4 (2002): 772-775.

members of the family.[55] Confucius is often quoted to have said to his students "our bodies to every hair and bit of skin are received by us from our parents." Therefore, children have the responsibility to take care of their parents in old age.

Demographic and socioeconomic changes have affected the familial traditions and their attitudes toward the elderly. One of the factors which influence the demographics was the migration from the rural to the urban areas. China's prosperous industrial centers on the eastern part of the country drew millions of workers like magnets away from their aging parents.

In addition the household registration system established in 1955[56] affected attitudes concerning the elders and their care of the elders in the families. The household registration system created by the government divided the population into the rural and urban areas. In many cases this motivated the children who migrated to the urban centers where there were increase job opportunities leaving the elderly members without resources. [57] They were virtually abandoned. Although many received help from their children in the cities, eventually they needed more financial assistance; and as a result many were left destitute. In addition in some very poor families, if the elderly could no longer work they were abandoned simply because the requirement for remaining in the family was their ability to work.

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[55] Pauk Nash, "China's Eldercare Predicament," *Diplomatic Courier,* December 17, 2013, http//www.diplomaticcourier.com/2013/12/17china-s-eldercare-predicament (accessed March 30, 2016).

[56] Haiyan Zhu, "Affiliate Unmet Needs In Long-Term Care And Their Associated Factors Among The Oldest Old In China," *BMC Geriatrics*, April 12, 2015, doi: 10.1186/s12877-015-0045-9 (accessed March 30, 2016).

[57] Ibid.

These events gave the rise to what became known as orphanages for the elderly. Many of these so called orphanages were located in Buddhist temples. One such orphanage was the Ji Xiang temple located in the mountains of China's southern Fujian province. Many elderly people will spend their final years in this temple because they have no financial resources and their families have abandoned them. The temple runs on a strict schedule which begins at 4am. The residents are expected to rise to study the Buddhist texts. This is followed by an hour of chanting before breakfast is served. This is a continuous pattern throughout the day: reading, chanting, eating. Neng Qing the temple head nun who is charge of the temple says that "there's not much family loyalty."[58] Qing makes daily trips travelling to surrounding villages to rescue elderly people who are suffering as the result of a lack of care. This existence is preferred by the elderly as opposed to the neglect and suffering which many experience in their villages.

The family planning policy in 1979 restricting only one child per family also has had an impact on the care of the elderly. As a result of this family planning policy elderly members had fewer family members to assist them in their later years and to provide them with financial resource. One child essentially would have the responsibility of four elderly grandparents. This placed a considerable hardship on the family. There are no government subsidized programs such Medicaid and Medicare. These factors combined to create a critical situation in terms of providing care for the elderly. These factors compounded the issue involving the care for the elderly in China.

[58] Celia Hatton, "China Who Will Take Care of China's Elderly People?" BBC News, Fujian Province, China, December 21, 2015, http//www.com/news/magazine-35155548 (accessed March 23, 2016).

The government has become aware of the plight of the elderly and their abuse due to these socioeconomic changes. In 2013 the government passed a national law, The Law of Protection of Rights and Interests of the Aged. The law is designed to protect the elderly. In addition the government has attempted to increase the awareness to the needs of the elderly by establishing a special day entitled Elderly Day which occurs in the fall. [59]

The recognition by the government of the current needs of the elderly as well as the recognition of the fact that their needs will increase as their numbers increase in the future have resulted in the development of some measures taken by the government to prepare for the future. In 1995 the Ministry of Health formed a working group for elderly health care. It also established a national Geriatric Institute to carry out research in areas which affect elderly care such as epidemiology, biochemistry, immunology, genetics, and cellular biology.[60] There are in existence presently about 50 organizations and 2000 health care workers throughout China. Community-based centers have been created in cities and rural areas to provide service for the elderly. The traditional values which have governed the care of the elderly in the past are being emphasized and taught again. Families are encouraged to establish written agreements will help avoid elder abuse and abandonment.

China is evolving to meet the needs of elderly. Choices are being made to a face the changing social and economic conditions. Traditional views are being modified in order to face the needs of the increasing elderly population. There has been a movement toward health care reform focusing on encouraging preventive measures to improve the

[59] Zhu, 56.

[60] Ibid., 55.

health of the elderly. They include improving diet; the reduction of high fat and high salt diets; and encouraging exercise to reduce obesity.[61]

Many Chinese are facing the reality that times have changed. When they are faced with issues concerning the care of the elderly they are no longer rejecting arbitrarily the possibility of a nursing home. The social economic conditions are requiring that they review this alternative. Li Wei, founder of the Songtang Hospice says the problem of the caring for the China's elderly is mainly an economic one, not an ethical one.[62]

This shift in the way the Chinese view the care of their elders is reflected in a survey of seven Chinese cities which revealed that the city of Nanjing had 27 nursing homes in 1990 and by 2009 the city 148 homes. Cities like Beijing and Tianjin showed similar growth.[63]

The government recognized this shift in family care of the elderly and developed a Five-year Plan (2011-2015) which advocates a senior care program that is not to mainly focus on support by families but which encourages support by community involvement, consisting of community nursing services and even a "meals on wheels" program.[64]

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[61] Ibid.

[62] "Ethical Tradition Meets Economics in An Aging China," Anthony Kuhn, *Morning Edition*, aired October 1, 2013, on NPR.

[63] Paula Span, "In China, A More Western Approach to Elder Care," *New York Times*, July 27, 2011.

[64] "China's Elder-Care Woes," *Shanghai Daily*, June 26, 2012, whttps://nursing.duke.edu/sites/default/files/centers/ogachi/chinas_elder-care_woes_feature_shanghai_daily_06262012.pdf (accessed March 23, 2016).

Japan

Japan has traditionally depended on families to care for their elderly. This responsibility was assigned to the women of the family specifically the daughter and daughters-in-law.[65] However, in the 21st century Japan was no longer able to meet the demands of the care for the elderly by the traditional care provided by the family. This task became increasing difficult with the lower birth rate and consequently fewer members of the family to care for the aging adults. The stress of taking care of the elderly members of the family led to situations of elder abuse.[66] A survey taken in 1994 confirmed the concern that in one out of every two families, caregivers had abused older relatives.[67] A policy known as social hospitalization was implemented in which the elderly were placed into hospitals for care.

The need to provide safe care for the elderly led to action by the government. In 2000, Japan developed a mandatory long-term care insurance system. This program is funded half by general tax revenues and half by a combination of payroll taxes and additional insurance premiums paid by everyone who is 40 years or older. The traditional family is the main source of care but the cost of care is subsidized by the government. Adult day care, home help and visiting nurse services are provided.

Although the introduction of a mandatory long-term care insurance system has helped ameliorate the problem, there continues to be a problem in terms of funding due to

[65] Chris Farrell, "What Japan Can Teach us About Long-Term Care," *Forbes*, August 24, 2015, http://www.forbes.com/sites/nextavenue/2015/08/24/what-japan-can-teach-us-about-long-term-care/#4455459d6296 (accessed March 30, 2016).

[66] Ibid.

[67] Ibid.

the increasing numbers and rising cost of care, in addition to a shortage of nursing care facilities for the elderly.[68]

[68] Philip Brasor and Masako Tsubuku, "Japan's Elderly Boomers Squeezed To Pay More As Care Facilities Struggle," *Japanese Times*, August 8, 2015, http://www.japantimes.co.jp/news/2015/08/08/business/economy-business/japans-elderly-boomers-squeezed-pay-care-facilities-struggle/#.VvyE-OIrLIU (accessed March 18, 2016).

CHAPTER 3
ASPECTS OF NURSING HOME CARE

Aging and Elder Care.

It is clear, as we go into the 21st Century, the care of the elderly population presents even greater challenges. These challenges can be experienced in various cultures such as the Native American Indian culture, the African American culture, the African culture, the Chinese culture and in other cultures throughout the world.

There is a crisis in our culture in terms of providing care for the elderly. For the most part the problem stems from the fact that currently there is an overwhelming volume of elderly who need care. The over sixty-five age group has experienced a population explosion. In 2006, the statics indicate that globally there were approximately 500 million people who were 65 and older. It is predicted by 2030 there will be over a billion people over sixty-five years of age, one out of 8 persons will be sixty-five or older.[69] This population explosion is greatest in the less-developed countries of the world. In addition, the fastest growing population in many countries is persons who are over eighty-five.[70]The appearance of the world will be very different. Because the number of persons over sixty-five will outnumber the children under five. We may eventually ask the question, "Where have our children gone?"

[69] National Institute on Aging, *Why Population Aging Matters, A Global Perspective* (Washington, DC: National Institute on Aging, 2007), 3.

[70] Ibid.

Longevity is the key word. People are living longer. Life expectancy is reaching far beyond the three score and ten and is being extended even beyond those years as promised in the Bible. The increase in life expectancy has been due to advances in science and medical research. With the increase in the elderly population there has also been an increase in non-communicable diseases such as high blood pressure, cardiac problem, diabetes, and high cholesterol, as well impairments due to joint and muscle malfunction. Medical research and discoveries have made it possible for this over-sixty population to survive these illnesses and impairments resulting in a long life in spite of these conditions. Many of the elderly are living today because of the high blood pressure medication which prevents strokes, the cardiac stents which have prevented them from going into cardiac arrest, the statins which continue to flush the arteries of the stroke producing and heart damaging cholesterol. As a result we are approaching what is referred to as a top-heaving population in which those over sixty are dominating the population profile.

There are challenges or consequences which have been created by this population explosion. Care for the elderly must be provided not only at the societal or governmental level, but also on a personal level. The elderly must be encouraged to prepare. The infrastructure must be in place to deliver the necessary care. An awareness of the challenges must be developed in the general population. In many cultures an awareness has develop and it is reflected in social support systems, new models of service delivery and in the changing of family traditions to meet the needs and care of the elderly.

It is clear that nursing homes and assisted living facilities are needed to face the challenges of this ever growing over sixty population There is a need to look at the

cultures of these places where as indicated by the statistics many of them will reside. It is important to increase opportunities to help them remain in contact with the lifestyles which they experienced before they have entered the group known as the elderly population.

Spiritual Concerns of Nursing Home Residents

When an elderly person enters a nursing home they experience a sense of loss because they are being disconnected from their normal lifestyle.[71] It is a painful change. Often they are suffering from some chronic health issues. They may have cognitive problems such as dementia. Over 45 % of nursing home residents suffer from dementia.[72] They can no longer live alone. Frequently residents experience boredom. It is difficult for them to become accustomed to organizational living. The managers of nursing homes and rehabilitation centers have no choice—they must operate on the basis of schedules and routines. The residents sense a loss of freedom and independence. Their past is absent. They are known only as they are in the present. They become simply names and numbers on a chart. A resident said to a member of the staff, "you don't know who I am."[73] She was known as the best cook in the neighborhood in which she lived. This loss of their past history adds to their sense of disconnection and their loss of identify and self-esteem. Our society tends to view individuals on the basis of what they do. If they reach a point in

[71] Melvin Kimble and Susan H. McFadden, eds., *Aging, Spirituality, and Religion: A Handbook* (Minneapolis: Fortress Press, 1995), 361.

[72] Dayle Friedman, "Spiritual Challenges of Nursing Home Life," in *Aging, Spirituality, and Religion: A Handbook*, ed. Melvin Kimble and Susan H. McFadden, 362-374 (Minneapolis: Fortress Press, 1995), 362.

[73] Ibid., 363.

life when they can no longer contribute or function as a part of society they are no longer considered to be of value.[74]

Religious rituals are important in the lives of those who have had previous spiritual connections. This is especially true of residents in nursing homes or rehabilitation centers. For example, Dayle A. Friedman points out in "Spiritual Challenges of Nursing Home Life," that when residents have a religious or spiritual connection, meaning is added to their lives. When their religious rituals are added to their daily lives it reduces their boredom, and loneliness. With the application of Jewish rituals concerning the understanding of time, for a Jewish resident it is s no longer Monday to Monday but from Sabbath to Sabbath. It gives the resident a sense of comfort. These rituals bring backs memories and restores a sense of continuity. Not only ritual experiences within the Jewish experience but also within the Christian experience or any religious experience, the practice of rituals bring back memories and restores a sense of continuity for the resident. A religious experience or service provided for the institutionalized elder removes a sense of "dependence, powerlessness and worthlessness."[75]

Religious services also develop a sense of community among the residents. It is not uncommon in nursing homes for residents to separate and isolate themselves and not to interact with each other. Worshipping together in a worship service brings them together and develops a sense of community. It not only connects those within the community but also connects them to the world outside of their community.[76]

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[74] Ibid., 364.

[75] Ibid., 367.

[76] Ibid.

CHAPTER 4
USE OF TECHNOLOGY IN NURSING HOMES

At the beginning of the 20th century technology began playing an increasing significant role in the operation and management of nursing homes In the 1960s, nursing homes were becoming the major care delivery systems for the elderly and as a result handwritten patient records locked in private doctor offices no longer could meet the needs of care delivery system of the elderly and those who required long term care. The health care system was becoming centralized. It was becoming an era in which medical information was being shared in order to provide better service for patients. The new technology primarily focused on the delivery of health care services and the improvement of the quality of services for the residents.[77]

In addition, a new development was introduced in the health care system which was designed for the elderly and in many situations replaces the traditional nursing home care system. This was known as assisted living nursing care. Assisted living nursing care units provided more opportunities on the part of the residents for self-care. Assisted living nursing care for the elderly provided care at a lower cost than the traditional nursing home care. The assisted care approach to elderly care was preferred by many

[77] Christian A. Mason, "Using Technology to Improve Delivery of Care," *Generations* 29, no. 4 (Winter 2005).

because it made it possible for the elderly to have an opportunity to remain at home in their familiar environment and receive care as needed.[78]

Management of assisted care facilities sought new methods of care which were more efficient than those found in the traditional nursing homes and as result turn to technology to improve the delivery of better health care services. Many of these technological innovations have taken the form of providing monitoring services for residents such as sensors which monitor resident locations, safety monitors which prevent residents from falling, touch screens located throughout the building which make it possible for staff members to be aware of all activities at all times

Technology has been used to provide opportunities for residents of nursing homes to and disabled persons who are shut-in because of a chronic illness to communicate with relatives. There are several technological vehicles which have been used as a means of increasing communication between residents and their families and friends: such as camcorders, Skyping and live-streaming. Residents are taught how to access the Skype program on their computers and how to use it connect via the internet to relatives and friends. The software is free and does not require any additional cost. This technology makes it possible for those residents who are located at a distance from their relatives to have opportunities to visit with them and to physically see them. This technology also makes it possible for those who are not only in nursing homes but are homebound because of their condition to have contact with loved ones and friends.[79]

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[78] Ibid.

[79] Claire Trapasso, "Senior Centers Turn To Skype To Connect The Elderly With Their Families," *New York Daily News*, November 27, 2011.

Senior centers have turned to Skype to train their residents and other interested seniors so that they can make contact with their relatives and friends. The following are some of the comments of those who have benefited from Skyping experience: a 79-year old man who suffers from leukemia, diabetes and a heart condition, states: "It [skyping] gives me a little something to look forward to; you don't feel so bad for yourself."[80] A woman who is a resident in a nursing home and has relatives in Hong Kong uses the Skype program at the nursing home and she is able to visit with her family in Hong Kong. She states, "I feel like I am communicating with my family face-to-face." It is clear that Skyping provides comfort and removes some of the loneliness experienced by those who are restricted by chronic conditions of sickness and disability from interacting with their family and friends on a regular basis.

Camcorders can provide the same service. Camcorders are cameras which are either built into a computer or they are attached on the surface of the computer. They operate like a video telephone making it possible to have one-on-one conversations. Both the skyping and the camcorder as well as what is known as live-streaming require internet service.

Live-streaming also transmits video and sound transmissions of event via the internet. Live- streaming is not restricted to one-on-one communication. Live streaming is designed to record events. The images of an event are sent to a receiver along with a sound component. Live streaming provides a panoramic view of an event. While live-streaming is not difficult to activate it does require more planning than skyping or the use

[80] Ibid.

of a camcorder.[81] It gives the receiver of the telecast the experience of actually being present at the event. For those who are sick and shut-in and who like to experience of being in a worship service, live streaming provides this opportunity. Live-streaming is an exciting technology. For those who are sick and shut-in and separated from the fellowship they once enjoyed, they have an opportunity to at least experience the fellowship once again. Live-streaming requires more preparation and planning than skyping or the use camcorders.

[81] Matt McCabe, *Live Streaming Excellence: How to Launch a Thriving Business Streaming Live Events* (n.p: Matt McCabe, 2015), Kindle Edition: Location 882.

CHAPTER 5
VIEWING THE DISABLED THROUGH THE SOCIAL, ECONOMIC AND POLITICAL LENSES

The factors which influence the image and care of the disabled and the aged are often social, economic and political. From a social perspective there has been a tendency in the past to ignore those who have a disability which tends to limit their ability to function in society. The social impact of a disability may be demonstrated in terms of how people interact with those with disabilities.[82] Often individuals feel uncomfortable in the presence of the disabled and they make assumptions about those who have disabilities. They assume that they are bitter or seek sympathy for their condition. These social attitudes tend to stigmatize and marginalize those with disabilities. Often negative attitudes toward the disabled affect how they respond to rehabilitation.[83] Those who are not disabled tend to respond in different ways to the disabled. Those with social and mental disabilities are viewed differently from those who have physical disabilities.[84] Those with physical disabilities often experience isolation and exclusion to a greater degree than those with social or mental disabilities because physical disabilities are more obvious and cannot be concealed. Various images have been projected which are designed to identify the disabled.

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[82] Shawn Lawton Henry, *Just Ask: Integrating Accessibility Throughout Design,* http://uiaccess.com/accessucd (accessed October 1, 2014).

[83] Ibid.

[84] Ibid.

Social Perspective

Society has come to view disability from two perspectives or models: a medical and a social model. The medical model views disability as an individual problem which results from a functional limitation which is the result of some type of impairment. The medical model attaches certain labels to the disabled. In a society which places value on independence, normalcy, "standing on your own two feet," the medical model implies that a person with a disability or who is disabled is basically a misfit.[85] The disabled person also represents an attack on the established view of what is considered to be normal. In contemporary Japan individuals who have disabilities are often discouraged from working, from marrying or attending movie theaters or restaurants.[86]

The medical model tends to identify those who are disabled or impaired as unattractive and undesirable and need to be fixed. Consequently, disabled persons are called upon to prove themselves and demonstrate that in spite of their disability, they can function. They are constantly required to prove themselves. It is the image projected by the medical model which during the Industrial Revolution created certain images of the disabled as non-functioning, and separated them from what was known as the so-called "able-bodied" worker who was needed to operate complex industrial machines. Those who had a certain disability would be excluded and considered to be a class of industrial

[85] John Swain, Sally French, and Colin Cameron, *Controversial Issues in a Disabling Society* (Buckingham: Open University Press, 2003), 22.

[86] Arnold Birenbaum, *Disability and Managed Care: Problems and Opportunities at the End of the Century* (Westport, CT: Praeger, 1999), 27.

rejects for whom provisions had to be made. This image would project their marginal status.[87]

This created a disability ideology that provided the basis for the institutionalization of disabled people by society. However, it also raised awareness that these images were oppressive and a form of inequality. As a result there was a need for what was known as normalization.[88] The medical model continues to project the disabled as needing special support and separate services.

The Union of Physically Impaired Against Segregation (UPIAS)[89] developed an alternate definition or model of disability which is known as the social disability model. The definition of impairment remains essentially the same. Impairment is defined as some malfunction of the body or bodily function such as hearing loss, vision loss, or the loss of the function of a limb; and this definition has been extended to cognitive loss as well.

However, the Union of Physically Impaired Against Segregation reframed the definition of disability in order to give a different perspective on the condition known as a disability. According to their definition there is a major difference between a medical disability and a social concept of a disability. Disability should not be viewed as something that happens to an individual but rather as something which is done to the individual by society.[90] In their definition, disability is no longer viewed as something a

[87] Patrick McDonnell, *Disability and Society* (Dublin: Blackhall Publishing, 2007), Kindle Electronic Edition: Location 320.

[88] Ibid., loc. 380.

[89] Swain, French and Cameron, *Controversial Issues in a Disabling Society*, 24

[90] Ibid., 29.

person has or become; but rather something society has done to the person to place them in the disability category It is a form of external pressure which is applied to an individual. One is disabled because society excludes the person by creating an environment in which the individual cannot function. This environment may take the form of physical barriers, legal barriers, cultural barriers, or attitudinal barriers. In this context, disability is a form of social oppression, not orchestrated by the individual but by society. The model of social disability provides a model of disabled persons who are normal persons who have become disabled because the society in which they live have set up limitations that affect their ability to function normally.

This view of disability lays the ground work for addressing social issues of justice. Questions are raised about attitudes and labels that stigmatize, marginalize and create powerlessness.[91] In view of this perspective, labels and language are carefully examined so that they don't create barriers which become oppressive. This definition of social disability calls for social justice. It demands that individuals are given opportunities which will make it possible for them to live to their fullest potential. This perspective of disability focuses on questions of citizen rights and civil rights.

The concept of social disability places the origin of disability not within the individual which is due to some physical disability but it recognizes that there is a form of disability which is created by societies that are organized in such a way to meet the needs of the non-disabled and to serve as barriers for the disabled.[92]

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[91] Paul T. Jaeger, *Understanding Disability: Inclusion, Access, Diversity and Civil Rights* (Westport, CT: Praeger, 2005), 15.

[92] Ibid., 23.

Economic Perspective

From an economic perspective beginning in the 19th century, the disabled population consisted of individuals who did not have the resources for self-care or management. They were often labeled as defective or deviant. "The disabled have experienced years or decades of discrimination and exclusion."[93] Awareness of this situation developed during the Industrial Revolution which eventually led to the understanding that the disabled should receive some economic support.

It became clear that there was a link between disability, employment and poverty.[94] Disabled people are usually in a poorer economic condition than those who are not disabled. This is true also from an international perspective. This condition is due to the fact that the disabled have had less opportunity for education and training and as a result experience much lower incomes. In situations in which the educational levels are the same, the disabled persons may not have the same employment opportunities.[95] This lack of economic power reduces opportunities for adequate housing, education and health opportunities. Many times impairment involves additional costs, medicines and special equipment. There is also the possibility of mobility problems such as inadequate transportation opportunities, which affect the ability of the disabled person to get to the workplace. The need for economic support leads to an understanding that participation in the workforce is a requirement for social inclusion. In order to equalize the economic field the disabled must be integrated into the workforce.

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[93] McDonnell, *Disability and Society*, loc. 55.

[94] Ibid., loc. 3447.

[95] Ibid., loc. 3470.

Awareness of the need for the social inclusion of the disabled into the work force in order to provide them with equal economic opportunity led Congress to pass the Americans with Disabilities Act (ADA) in 1989.[96] This law is sometimes referred to as the Emancipation Proclamation for disabled people. In order to bring about inclusion it may be necessary to redefine what we mean by work. The Americans with Disabilities Act opened up doors for opportunities for employment for those who had disabilities. It required employees to accommodate qualified individuals with disabilities. It was noted that at that time that accommodations for disabled persons cost less than fifty dollars per person. By providing gainful employment for disabled persons it would make it possible for them to become taxpayers and as a result assist in reducing the fifty-seven billion in Federal Funds which was spent annually to provide disability benefits and programs. At this time at least 8.2 million disabled persons would like to work but cannot find employment. The ADA also provided requirements for proper accommodations and accessibility to public facilities such as restaurants, retail stores, hotels and doctor's offices.[97] The ADA stated that no governmental state or local agency could deny employment to a qualified disabled person. Efforts were made by the ADA to insure that transportation would not be a major problem. Buses and other modes of transpiration were to be designed to be disabled accessible.

Recent studies have indicated that the concept of work should not be based on the Western model in which profits, wages and competition between individuals are the ingredients which define work. Disabled people with "functional limitation or

[96] William McCrone, "Senator Tom Harkins; Reflections on Disability Policy," *Journal of Rehabilitation* 56 no. 32 (April-June1990).

[97] Ibid.

impairment"[98] cannot function well in that type of environment because they feel that they cannot function on the same level of those who are not disabled. Work should be centered on a sense of interdependence for the disabled. This could be accomplished by giving the disabled opportunities to become providers of goods and services.

Political Perspective

From a political perspective it became clear that action was necessary to give disabled individuals needed assistance. In March 2000, in Sandusky, Ohio, Kelly Dillery, disabled as the result of muscular dystrophy was arrested for driving her motorized wheelchair in the city street because the sidewalks were damaged and broken and as a result inaccessible for her. She became a cause célèbre for disability rights—she was labeled the Rosa Parks for disability rights.[99]

The history of political activity for the disabled can be divided into four periods or time frames:

1. 1700-1920 was a period when extended families cared for the disabled, which society generally viewed with indifference.
2. 1920-1960 was a period when political emphasis was directed toward the improvement of rehabilitative medicine and efforts to educate the public concerning the needs of disabled persons, while keeping the disabled in segregated settings.

[98] Ibid., 45; McDonnell, loc. 3529.

[99] Jacqueline Vaughn Switzer, *Disabled Rights: American Disability Policy and the Fight for Equality* (Washington, DC: Georgetown University Press, 2003), 1.

3. From 1960-1975, we see the development of the disability rights movement and some legal reform.
4. After 1976, political action focused on a more expansive rights movement, which faced a more restrictive interpretation of disability rights.[100]

Obtaining normalization rights for the disabled was a slow process. In the middle of the 20th century in Europe and the United States individuals with disabilities were often treated like "freaks." Families sold their disabled children for exhibitions. They often appeared in circuses and carnivals such as those sponsored by P. T. Barnum

Political action was taken in the United States in 1935 to meet the needs of the disabled. President Franklin D. Roosevelt called for legislation to provide assistance for the unemployed, the aged, destitute children and the disabled. The Social Security Act of 1935 was instrumental in beginning the process of providing assistance in the form of pensions for the disabled. In 1972 the Committee on Labor and Public Welfare passed the Rehabilitation Act which extended the vocational and rehabilitations programs. It was designed to reach out to the more severely disabled persons and provide additional rehabilitation opportunities for them. Section 504 which became law indicated that "no qualified handicapped individual in United States…shall solely because of his/her handicap be denied participation in any program receiving financial funds from the Federal government."[101] Not only in United States but there was a global reaction to the plight of the disabled and the recognition that the disabled were entitled to some basic rights, namely a life of inclusion and equality. Shortly after the Committee on Labor and

[100] Ibid., 31.

[101] Richard K. Scotch, *From Good Will To Civil Rights* (Philadelphia: Temple University Press, 2001), Kindle Electronic Edition: Location 540.

Public Welfare passed the Rehabilitation Act, in March 1972, protesters from the (DIA) Disabled in Action carried out demonstrations occupying the Lincoln Memorial in Washington DC and Nixon's re-election headquarter in New York. They also filed suit under the Americans Disabilities Act to demand that the owners of the Empire State Building provide ramped access to the observation tower.[102] These political actions helped in an effort to remove the disabled from a marginal status in society and remove the political rational for the institutionalization of disabled people by society.

An act of social and political activism laid the groundwork for political change. On March 6, 1988 there was an event at Gallaudet University in Washington D.C., a university founded under a federal charter for the Deaf and Blind. The Board of Trustees hired a president, Elizabeth Ann Rinser, who was not deaf. In one hundred and twenty-five years there had never been a deaf person who was president of the university. This action traumatized the university but it also had political reverberations throughout the world.[103] This event impacted American disability policy. The student protests were visible in the media, drawing attention to the fact that disabled individuals were determined, resented oppression and sought to diffuse the stereotypical images and labels associated with their disability.

There were those who compared the attention drawn to this event to that associated with the civil rights protests in the 1950s and 1960s. The DPN ("Deaf President Now") protests spearheaded the steps needed to create the American Disability Act.[104]

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[102] Switzer, *Disabled Rights*, 59.

[103] Ibid., 66.

[104] Ibid.

CHAPTER 6
VIEWING THE DISABLED THROUGH BIBLICAL AND THEOLOGICAL LENSES

The biblical concept of disability has its origin in philosophies of Aristotle and Plato and their understanding of matter and form.[105] Aristotle looked for perfection in the form of matter. This point of view was applied to how he viewed the human body, *soma*. Aristotle's emphasis on perfection could only be found in perfect physical form.

> Aristotle suggests, with humans as with animals, any physical difference that departs from type (i.e. the able-bodied male) becomes a "monstrosity" that is one not only less than ideal but also less than human.[106]

Therefore, Aristotle describes any imperfection in a human being such as physical malformation, impairment of hearing, impairment of vision, mental retardation, children with birth anomalies, as a deformity and a disability. He also classifies women as representative of a deformity or defective form. In contrast Plato emphasized the concept of the ideal form which may or may not exist in the physical world in the form of matter. According to Plato the truth of the world or true form does not necessarily exist in matter. Truth or true form is found in the spiritual or non-physical world. Matter as we know it may not be a true reflections of images found in the non-physical or spiritual world. Plato prepares the way for the development of the tension between the body, *soma* and the soul, or form and matter. Aristotle's emphasis on finding perfection only in the form of

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[105] Deborah Beth Creamer, *Disability and Christian Theology: Embodied Limits and Constructive Possibilities* (New York: Oxford University Press, 2009), 40.

[106] Ibid., 41.

matter introduced the concept of defining what is normal. In terms of disability, the world of the Bible reflects both the concepts of Aristotle and Plato.

The Aristotelian concept of normality versus abnormality is reflected in how the Bible identifies those who are classified as disabled. The Bible views disability as an abnormality reflecting the Aristotelian concept of perfection. Therefore, those who are blind, deaf, have leprosy or who are paralyzed, are considered to be disabled.

From a biblical standpoint there are several possible reasons why an individual may become sick and as a result considered to be disabled. The Bible indicates that disability may come as the result of disobedience to God and his laws. For example, Samson violated his Nazarite vows and as a result became blind because of his disobedience (Judges 16:21). The theme that punishment comes as a result of disobedience to God and his laws is a theme which runs throughout the Bible.[107] In the book of Deuteronomy, God responds to the wrongdoing of the people by inflicting them with disease and sickness. The Lord says: "I kill and I make alive; I wound and I heal" (Deuteronomy 32:39). It is clear in these references that God controls the infliction of disease which can result in some form of disability. Disease is a sign of God's wrath. Miriam, Moses' sister, develops leprosy. David's independent decision to conduct a census results in God's wrath descending upon him and 70,000 people of Israel are afflicted with a pestilence as a form of punishment.

The Bible gives examples of disabilities that come about to test the faith of a believer. Job is an example of such testing. His faith was tested by sickness and misfortune. The Bible gives examples in which disabilities may come about to

[107] Creamer, *Disability and Christian Theology*, 42.

demonstrate God's power. In II Corinthians 12:9 Paul says, "I will boast all the more gladly of my weakness, so that the power of Christ may dwell in me." In John 9:3 Jesus says that the man "was born blind so that God's works might be revealed." The Bible declares that redeeming power comes as the result of an incident which produces a disability. The crucifixion of Jesus is an example of such a process. Paul's declaration of a thorn in his flesh and God's response: "My grace is sufficient," is an example of a pedagogical interpretation of suffering which may reveal itself in the form of a disability. It is said that God is teaching the individual something through his/her suffering.[108] The Bible also identifies a disability which provides an opportunity for what is known as "charitable activity."[109] David was able to extend kindness or perform a charitable act to Mephibosheth, Saul's grandson, because of Mephibosheth's disability.

In contrast to the theme of punishment for sin and disobedience there is a promise of health and well-being for those who are faithful and obedient to God.[110] "God says: If you will diligently hearken to the voice of the Lord your God and do that which is right in his eyes and give heed to his commandments and keep all his statutes. I will put none of the diseased upon you which I put upon the Egyptians for I am the Lord your healer."

This takes the form of restoration and the removal of the oppression which may be caused by the disability. The restoration is usually performed by an act of healing.

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[108] Jeffry R. Zurheide, *When Faith Is Tested* (Minneapolis: Fortress Press, 1997), Kindle Electronic Edition: Location 278.

[109] Pauline A. Otieno, "Biblical and Theological Perspectives on Disability: Implications on the Rights of Persons with Disability in Kenya," *Disability Studies Quarterly* 29, no. 4 (2009), http://dsq-sds.org/article/view/988/1164 (accessed January 17, 2016).

[110] Creamer, *Disability and Christian Theology*, 44.

Jesus at the very beginning of his ministry declares that his mission is one of restoration. In Luke 4: 18-19 Jesus declares:

> The spirit of the Lord anointed me to preach the good news to the poor.
> He sent me to proclaim freedom for the prisoners and the recovery of sight
> For the blind, to release the oppressed, to proclaim the year of the Lord's favor.

However a theme still runs through the New Testament that indicates that sickness and disability is the result of sin or the disobedience to the laws of God. In John 5:14 Jesus says to the disabled man he healed at the pool of Bethesda: "See, you are well again. Stop sinning or something worse will happen to you."

Therefore, it can be said that the concept of disability in the Bible is viewed from both a negative and positive perspective.[111] On the one hand, the Bible views a disability as a punishment for one's sin, or for the sins of another, or a test, of faith, an effort to build character or as a means of inspiration for others, and an opportunity to demonstrate God's power or simply an unexplainable act of God.[112]

Current Theological Views on Disability;

In a recent effort to remove the stigma associated with disability and to develop an understanding that there is diversity; individuals with disabilities should not be viewed as objects. There are theologians today who believe that we should alter the image of a God who is the all-powerful God who acts like a "puppeteer."[113]There should be an understanding that we all are to some extent disabled and that we should recognize our interdependency. We need to accept the fact that God is not responsible for all of the

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[111] Creamer, *Disability and Christian Theology*, 49.

[112] Ibid., 50.

[113] Kathy Black, *A Healing Homiletic: Preaching and Disability* (Nashville, TN: Abingdon Press, 1996), 34.

negative events that take place. We need to recognize that we are all dependent on each other.

Those who are disabled understand the meaning of dependency and those of us who are not disabled need to recognize that we too are dependent on each other. Theologians have come to view God not as perfect or unblemished but one who himself was blemished and who has the marks of disability. Nancy Eiesland in her book gives an example of man, a quadriplegic who was in a sip-puff wheelchair, was asked to respond to the following question: "If God was in a sip-puff wheel chair, a quadriplegic, what would His reaction be?" His reply: "If God was in a sip-puff, maybe He would understand." Not an omnipotent, self-sufficient God but neither a pitiable, suffering servant. This was an image of God as a survivor, as one of those whom society would label "not feasible," unemployable, with questionable quality of life."[114]

Nancy Eiesland supports the concept of a disabled God or a God who is not perfect in form. She uses as her example Jesus' appearance after the resurrection when he appears to his followers with pierced hands and feet and a hole in his side. She also supports the social model of disability. She supports this view by stating that claims made by such theologians such as James Cone that Jesus was black reflect this tension and this model of oppression, namely that the environment, political, economic or social which is oppressive can create disability.[115]

Jennie Weiss Block views a disabled human being as an eternal child. Such a child is not expected to experience normal development nor is he held accountable for his

[114] Nancy L. Eiesland, *The Disabled God: Toward a Liberatory Theology of Disability* (Nashville, TN: Abingdon Press, 1994), 85.

[115] Ibid., 37.

actions.[116] This model removes all responsibility for human behavior. He lacks characteristics such as capability, responsibility or culpability. The father child model tends to objectify the disabled person by removing all sense of personal responsibility.

Sallie McFague views disability as an accident or an example of randomness. She views disability as not an act of God that makes a decision to inflict with an impairment that develops into a disability. It is simply a chance occurrence.[117] Sallie McFague also embraces the concept of the embodiment theology as it relates to disability. We all are representations of human embodiment. This human embodiment provides experiences which are not uniform but diverse. Some human embodiments experience blindness, deafness, and cognitive impairments. However, we are a part of the human experience. McFague's position is that current theology should engage in reflections that includes an understanding of the diversity of human experience.[118]

The Bible looks upon the elderly and aged with favor and high esteem. It grants human beings a life span of three score and ten, seventy years. However, today, with medical advances and better living conditions, according to a study of the Department of Population and Economic Social Affairs of the United Nations, in the year 2000 over 66 million people were eighty years of age or older.

The Bible demands respect for the elderly:

"Stand up in the presence of the aged, thus shall you fear God" (Leviticus 19:32).

"Honor your Father and Mother" (Deuteronomy 5:16).

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[116] Ibid., 50.

[117] Ibid., 51.

[118] Ibid., 11.

The Bible views old age as a time for increased opportunity and productivity and not simply a time to wait to die. Psalm 91:10 "They shall bear fruit in old age." The Bible also attributes wisdom to the aged and elderly and challenges society to make available opportunities for the elderly to share their wisdom and experience.

In biblical, as well as classical, literature old age is viewed as an example of strength and potential power and influence.[119] "Decrepitude was not always the fate of biblical heroes who lived long lives. Saul suffered from severe bouts of mental illness throughout adulthood, but he was strong enough at age seventy to fight to his death in the battle of Gilboa."[120]

Moses, at the age of ninety is still represented as a source of strength and still possessing the ability to lead a people. In the Bible women are also presented as individuals who were still vital and able to makes valuable contributions even beyond normal childbearing years; Sarah in her nineties is said to have given birth to Isaac. And Elizabeth in her old age gave birth to John the Baptist, the forerunner of Jesus.[121] Not only in the Old Testament but also in the New Testament there were councils of elders, although they were not all elderly, who led in an advisory capacity.

It is clear that the Bible recognizes and affirms the possibility of individuals continuing to make contributions to life. These individuals continue to demonstrate

[119] Andrew Achenbaum and Stephen Bertman, "Aging and Spiritual Empowerment: The Stories of Oedipus and David," in *Aging and the Religious Dimension*, ed. Eugene Thomas and Susana. Eisenhandler, 67-84 (Westport, CT: Auburn House, 1994).

[120] Ibid., 73.

[121] Ibid., 69.

spiritual invigoration and power.[122] According to the Bible many of these individuals in their seventies, eighties and nineties were used by God to carry out his divine will.

Exegetical Analysis of 2 Samuel 9:5-7

Topic: The King's Table: Scripture: 2 Samuel 9:1-12

9:1 David asked, "Is there anyone still left of the house of Saul to whom I can show kindness for Jonathan's sake?"

9:2 Now there was a servant of Saul's household named Ziba. They summoned him to appear before David, and the king said to him, "Are you Ziba?"

"At your service," he replied.

9:3 The king asked, "Is there no one still alive from the house of Saul to whom I can show God's kindness?"

Ziba answered the king, "There is still a son of Jonathan; he is lame in both feet."

9:4 "Where is he?" the king asked.

Ziba answered, "He is at the house of Makir, son of Ammiel in Lo Debar."

9:5 So King David had him brought from Lo Debar, from the house of Makir son of Ammiel.

9:6 When Mephibosheth son of Jonathan, the son of Saul, came to David, he bowed down to pay him honor.

David said, "Mephibosheth!"

"At your service," he replied.

9:7 "Don't be afraid," David said to him, "for I will surely show you kindness for the sake of your father Jonathan. I will restore to you all the land that belonged to your grandfather Saul and you will always eat at my table."

9:8 Mephibosheth bowed down and said, "What is your servant, that you should notice a dead dog like me?"

[122] Ibid., 79.

9:9 Then the king summoned Ziba, Saul's steward, and said to him, "I have given your master's grandson everything that belonged to Saul and his family."

9:10 You and your sons and your servants are to farm the land for him and bring in the crops, so that your master's grandson may be provided for. And Mephibosheth, grandson of your master, will always eat at my table." (Now Ziba had fifteen sons and twenty servants.)

9:11 Then Ziba said to the king, "Your servant will do whatever my lord the king commands his servant to do." So Mephibosheth ate at David's table like one of the king's sons.

9:12 Mephibosheth had a young son named Mika, and all the members of Ziba's household were servants of Mephibosheth.

9:13 And Mephibosheth lived in Jerusalem, because he always ate at the king's table; he was lame in both feet.

Statement of the Problem

"Issues about disability have been a global concern. Efforts have been made to normalize the status of disabled individuals in society. Political, economic and theological conversations have been made to draw attention to the need that the disabled need emancipation."[123] This pericope, 2 Samuel 9:3-7, is selected for this exegetical analysis because it focuses on an individual who has a disability, Mephibosheth. The question is does David's behavior in this pericope demonstrate his concern about the disabled? Is this a hermeneutic application supported by the pericope?

Historical Context

The events of this chapter take place several years after David's capture of Jerusalem. David is found as a successful warrior at this point. He has purged out the area surrounding him. Among his conquest are the Philistine, Moabites, and the Edomites.[124]

[123] Eiesland, *The Disabled God,* 19.

[124] William MacDonald and Arthur L. Farstad, *Believer's Bible Commentary* (Nashville, TN: Thomas Nelson Publishers, 1995), 330.

His kingdom is secure. At the death of Saul, as is the oriental custom, it is expected that he put to death all contenders to his throne which include all of the relatives of Saul.

Literary Context

2 Samuel is a historical narrative. The human author is unknown.[125] Originally, First and Second Samuel was a single book. A considerable amount of the information in the beginning of First Samuels applies also to Second Samuel. The name of 2 Samuel really does not apply to Samuel, himself because he died before 2 Samuel was written.[126]

Significance of Biblical Terms

Mephibosheth or Meribbaal, meaning from the mouth of shame. *Lo Debar* meaning no pasture.[127]

Text

2 Samuel 9:5-7

9:3 David raises the question: Is there not yet anyone of the house of Saul to whom I may show the kindness of God. This is an interesting question in light of the fact that it was traditional that all of the relatives of previous kings were normally executed. Apparently this is not the intention of David because he says he wants to show God's kindness. Ziba's response is that there is son of Jonathan

9: 4-5 David has Mephibosheth brought from Lo Debar

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[125] Michael Rydelnik and Michael G. Vanlaningham, eds., *The Moody Bible Commentary* (Chicago: Moody, 2014), Kindle Electronic Edition: Location 15672.

[126] Michael David Coogan, Marc Zvi Brettler, Carol A. Newsom, and Pheme Perkins, eds., *The New Oxford Annotated Bible: With the Apocryphal/Deuterocanonical Books* (New York: Oxford University Press, 2001), 445.

[127] MacDonald and Farstad, *Believer's Bible Commentary*, 333.

9:6-7 David, upon meeting with Mephibosheth, tells him not to be afraid and that he will show him kindness and that he will restore all of the land belonging to his grandfather Saul and that he will always have a seat at his table to eat.

David keeps his promise he made to Jonathan by providing for Mephibosheth, his son. Some commentaries indicate that David's real intention was to keep Mephibosheth in sight so that he would not be a threat to his kingdom.[128] Other commentaries point out because he was disabled under Jewish Law he would be unfit to be king.[129]

Conclusion

The text makes it clear that David, the prototype of Jesus, was a man who kept his promises. He promised Jonathan that he would take care of him "for the sake of his father." This was his primary concern. He did not see Mephibosheth as threat to his power because he was crippled and Jewish Law would consider him to be unfit to be king.[130] Yet David had the courage to care for him in spite of the Jewish culture which at that time relegated the crippled and disabled to the margins of society.[131] Although the text may not echo directly the support for the disabled or the infirm, nevertheless, the image of Mephibosheth with crippled feet dangling below the king's table is a powerful image. This image resonates with the words of Jesus in Luke 22:30 when he said. "That ye may eat and drink at my table…"

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[128] James D. G. Dunn and J. W. Rogerson, eds., *Eerdmans Commentary on the Bible* (Grand Rapids, MI: W. B. Eerdmans, 2003), 235.

[129] Jeremy Schipper, *Disability Studies and the Hebrew Bible: Figuring Mephibosheth in the David Story* (New York: T & T Clark, 2006), 1.

[130] Ibid.

[131] Tzvi C. Marx, *Disability in Jewish Law* (New York: Routledge, 2002), 17.

CHAPTER 7
PREPARATION FOR THE JOURNEY

The Selection of the Fellow Travelers: The Site Team

The site team was selected to provide assistance for the journey. The members of the team were my mentor and advisor, to provide guidance for the journey; a psychologist, to evaluate the concerns and needs of the passengers—the residents of the nursing home and rehabilitation center; two technicians who will execute the video streaming; and helpers, one of whom had been a former resident of the nursing home.

Developing Awareness of the Need for the Journey

The plan of implementation involved developing an awareness of the need to reconnect the residents of the Nursing Home and Rehabilitation Center to their houses of worship. Conversations with the therapeutic recreational director revealed the fact that many residents experienced a certain sense of abandonment and disconnection as the result of their separation from the worship and fellowship of their church families.

Members of the congregation were called together in order to develop an awareness of the proposal, its goals and objectives. A Bible study and a workshop were organized to develop an awareness of the need to make this connection. Before and After Questionnaires were prepared and distributed to evaluate the level of awareness and concern of the members of the congregation.

"Making room at the King's Table" was the theme of the Bible Study. It was based on 2 Samuel 9:1-12. The objectives of the Bible Study were to (1) to focus on the

attitudes and views of the Old Testament concerning the disabled; (2) to understand how David circumvented them; and (3) to understand and sensitize us as a congregation in the 21st century to the spiritual needs and concerns of the disabled. Questions which were discussed:

- What led Mephibosheth to refer to himself as a "dead dog"?
- Would you say he had an inferiority complex because of his disability?
- How would you say physical appearances and or disabilities affect relationships?
- Why do you think that this story is most often used to advocate for those who have a disability or handicap?
- What are some of the ways we can reconnect the disabled, the sick and the shut-in to the "body of Christ".

On March 28, 2015, a workshop was held. The presenter was the therapeutic recreational director at the nursing home and rehabilitation center. The purpose of the workshop was to reinforce and develop the awareness of the spiritual needs of residents who desired to be reconnected to worship experiences which they have experienced in the past.

During the course of the workshop the therapeutic director informed the workshop participants that even though the residents are provided with a mandated worship service by the nursing home there is still a desire on the part of the residents to be connected to a live worship service. When newly admitted residents arrive at the facility they will frequently express this need. They may ask the question: "Is there any church here?" This is particularly true of those residents who were regular attendees at

houses of worship before they came to the facility. The director pointed out that many desired to hear the songs, the prayers and the sermons which they have enjoyed in the past and communicate with their pastor and enjoy the fellow of the members of the church.

The therapeutic director of the nursing home encouraged the members of the congregation to make an effort to maintain a connection with those who are in the nursing homes and rehabilitation centers. She encouraged them to stay connected to their church family even when they are in a nursing home for a short time or for an extensive period of time. To emphasize how important the worship was for the residents she recalled a resident who desired to reconnect with her church fellowship and her pastor. This was made possible when one of the members of the church visited her and she was we able to make the contact for her. Again the emphasis was placed upon the importance of maintaining and connecting with a church family. The director also provided information on how one should visit. She also stated although one may visit a particular resident, one should be cordial to other residents because some residents may have few visitors. Following the presentation, a very lively discussion ensued. This was followed by the distribution of the questionnaires.

The focus or control group consisted of 15 members of the church. The staff and the residents of the facility were not permitted to participate in the questionnaires because of the HIPAA regulations.[132] The "Before and After" questionnaires were reviewed, and the evaluation revealed that 13 out of the 15 members of the focus or control group or

[132] Jarrett Law Office, "HIPAA," http://vtelaw.com/index.aspx?TypeContent=ARTICLES&Art_Title=HIPAA,_not_HIPPO_(5_2010)&art_id=1759 (accessed December 29, 2015).

87% indicated that their attitudes about nursing homes and rehabilitation centers had changed. They indicated that they were more aware of the spiritual needs of the residents and their need to reconnect with the fellowship and worship of a house of worship.

CHAPTER 8
PATHWAYS LEADING TO THE RECONNECTION

Methodology

Once the decision was made not to live-stream the worship service by means of Skype, certain equipment and technical services were needed: such as a camcorder to record the images, the availability of a Wi-Fi contact to provide an internet connection and a service provider for the live-streaming.[133] The decision not to use the Skype technology was based on the fact that Skype live-streaming did not provide a panoramic view of the audience or the congregation during the live streaming. It provided only a limited view of the services because only those activities directly in front of the lens on the computer could be live-streamed. The camcorder made it possible to provide a panoramic view of the service zooming in and out on the various activities as needed.

In order to transmit or download the images from the camera to the internet to do the live streaming, a video service was required. I chose the service provider UStream; there are other services which are available such as Justin TV and Yahoo Live.[134] The sites were prepared to receive the internet connection. At the nursing home the Wi-Fi connection was activated making it possible for the nursing home to receive the live-stream broadcast of the worship services from the church. At the same time the Wi-Fi

[133] McCabe, loc. 555-565.

[134] Streamingmedia.com, "A Buyer's Guide to Live Streaming Services," http://www.streamingmedia.com/Articles/Editorial/Featured-Articles/A-Buyers-Guide-to-Live-Streaming-Services-95465.aspx (accessed January 17, 2016).

connection was activated at the church and connected to the camcorder so that the images of the worship services could be transmitted from the camcorder to the internet and processed by the service provider, U-Stream, and transmitted to the nursing home television set for viewing by the residents.

The Process: Challenges and Roadblocks

Technological problems presented a challenge. Although our technician had some knowledge of the live-streaming process it was not sufficient to operate the equipment. Part of the development of my ministerial competences was to develop the ability to be able to assist and to aid in the development of the members of the team and to confront issues without offending. I found Deborah Smith Pegues's book, *Confronting without Offending* very helpful. I became a better listener and as a result increased my ability to validate the feelings and thoughts of the team members.[135] Focusing on this competency I encouraged the technician to do research and to obtain the assistance of an individual or individuals who had live-streaming experience. A meeting was held with a technician from a neighboring church which had been live-streaming for many years. The major problem was learning how to adjust the camera so that it would capture the images and transfer them to the internet. This problem was finally resolved with the assistance of the technician from the neighboring church.

Not only was there a problem in terms of learning how to operate the camera and make the necessary internet connections, but there was the constant request for additional electronic equipment. I later realized that these requests were due to the fact our

[135] Deborah Smith Pegues, *Confronting without Offending* (Eugene, OR: Harvest House Publishers, 2009), Kindle Electronic Edition: Chapter 10, Location 1476.

technician was struggling to understand the technology involved in the live-streaming process.

Financial problems were a major roadblock. The camcorder or camera which was needed for the live streaming cost approximately fifteen hundred dollars. I was given a scholarship of a thousand dollars which I used to purchase the camera plus an additional contribution of six hundred dollars. I literally had to wait for these funds and for a time the implementation of the project came to a complete standstill.

Logistic problems developed which might be characterized as challenges or blockades. It was necessary to determine which of the community rooms at the nursing home would be used to view the video transmission. It was necessary to secure a member of the staff who would be available on the days on which the video-streaming would take place.

CHAPTER 9
THE ARRIVAL: MAKING THE CONNECTION

It was not until noon of the day prior to our target date to transmit our first live stream broadcast that it was certain that it would be successful; that the goal would be achieved. There were still technological glitches. I informed the technicians that it was necessary that I know by noon whether we would be ready to live stream as scheduled on Easter Sunday. This information was necessary because the residents needed to be prepared and transported to the community room where the live- stream broadcast would be received. This required preparation time and a schedule was necessary. By noon as requested I received the okay from technicians on the site team that the transmission of the live-stream would be ready to broadcast on the next day, Easter Sunday, Resurrection Sunday. I notified the nursing home.

Easter Sunday, Resurrection Sunday, April 14, 2015 was a bright and sunny spring morning. At 8:00 am. I arrived at the church. The site team assignments were in place. The camera person was at the camera position in the balcony of the church; a second member of the site team was at the nursing home to monitor the quality of the transmission. I arrived at the nursing home and the nursing home was prepared to receive the live-stream broadcast of the worship service from the church; or so I thought.

I had been repeatedly in contact with the nursing home during the week. I was informed that they were prepared to receive the reception. The member of the site team who was the contact person for the nursing home also assured me that everything was

ready to receive the reception. But at the last minute there was a major problem that threatened to nullify our efforts. The contact person at the nursing home had not obtained the password for the internet connection. This meant that we could not go on-line. The nursing home could not receive the reception. I believe that God stepped in. My niece, who is computer savvy, called me and informed me that she was viewing the live–streaming of the service on her computer at home. I shared with her the problem. She informed me that I should use the hot spot on my cell phone to get the internet connection. I just did not know how to do that. She came to the nursing home to show me how to use the hot spot on her cell phone to get the internet connection and live-streaming of the worship service was transmitted to the residents who enjoyed the service. Through the grace of God the journey was completed. The residents were reconnected to a worship service. They enjoyed the service. They received a personal Easter Greeting from the pastor. They were part of the worshipping fellowship. The members of the site team as well as the congregation, were excited by this experience.

The journey had been completed. The vision had become a reality.

CHAPTER 10
REFLECTING ON THE JOURNEY THROUGH THE LENS OF MY MINISTERIAL COMPETENCIES

I met with the Site Team in August of 2014. The following suggestions were made concerning the areas in which I could improve my ministerial competences: spiritual leadership, interpersonal skills, and professional organization. I embarked on an effort to increase my involvement in spiritual discipline and practices and I used as my guide the book by Richard J. Foster, *Celebration of Discipline.*

Competency 1: Spiritual Discipline

I embraced the thought that "the discipline of the spiritual life allows us to place ourselves before God so that he can transform us."[136] As a result I began to engage in consistent prayer as I began putting my project together. For a time I attempted to set aside a prayer time four times a day: 9:00 A.M., 12:00P.M., 6:00P.M., and before I went to bed. I was not able to keep that schedule; however, this experience did make me more prayer-conscious. When decisions had to be made concerning the project I tended to pray first before making a decision. When it appeared we were not going to reach our due dates, rather than become discouraged I prayed. When tragedy came upon us in the case of unexpected passing of the therapeutic recreational director, Ann Simmons, who had been such a tremendous resource person as we initiated the video streaming at the facility, we prayed. Her passing left an impact on me as well as the site team and our

[136] Richard J. Foster, *Celebration of Discipline* (New York: HarperCollins, 1988), 7.

church congregation. She was such a tremendous resource to the project both physically and spiritually

As I attempted to further deepen my spiritual leadership I began engaging in daily Bible study. I prepared daily sermons and commentaries based on the Bible. I took a course on Spiritual Formation sponsored by the Eastern Baptist Association Christian Education Department in February 2015, held at the Union Baptist Church Hempstead, N.Y. The course was taught by the Rev Dr. Johnny Tuner. It focused on spiritual formation from the point of view of discipleship, its impact on one's personal walk, the role of the Holy Spirit and its effect on the faith community. I found this course particularly helpful as I viewed my project through these lenses. This project encapsulated discipleship, reflecting Jesus' mandate to teach and preach his Way. It also reflected the need to concentrate not only on one's own personal spiritual walk but also to become aware of the spiritual needs of others and to raise the consciousness of the faith community to the needs of those who have been disconnected from the worshipping community. This conversation was very helpful because it was directly connected to the goals of my project.

Competency 2: Interpersonal Skills

My site team suggested that improvement was needed in how I handle my interpersonal relationships, more specifically how I offered constructive criticism. I used as my resource the book *Confronting without Offending*, written by Deborah Smith Pegues. She describes the different styles of leadership, which I found very informative:

- The Dictator: "Do It My Way," handles conflict by using his/her power or anger to settle the problem at the expense of the other person.

- The Accommodator: “Have it Your Way,” handles conflict by acquiescing to the requests or demands of the other person. They might be described as “people pleasers.”
- The Abdicator: “I’ll Run Away” deals with conflict by escaping. He/she tends to retreat from the conflict either physically or emotionally. He/she will avoid conflict at any cost.
- The Collaborator: “Let’s Find a Way” attempts to find a point of agreement. He/she cooperates, attempts to create unity, find a common goal. The collaborator is concerned about relationship and has respects for the concerns of others. [137]

A seminar was organized with the members of my site team entitled “Developing Skills in Conflict Management.” The seminar moderator was Dr. Francine Angel Hernandez. We engaged in role playing activities demonstrating the different leadership styles. This activity helped me and members of the site team to identify our leadership styles and the role it plays in how we manage conflict management. As a result of the seminar, my readings and my interactions with the members of the site team I able to identify my often non-productive Dictatorial style of leadership referred to as “Do It My Way.” As I worked with the technicians on the project I had to recognize that my “Do It My Way” style of leadership did not produce the desired results. I recognized that I needed to embrace the collaborative style of leadership in terms of conflict management not only to get the project moving but also to keep from offending members of the team.

[137] Pegues, *Confronting without Offending*, Ch. 5, loc.787.

Personal Evaluation

I demonstrated my spiritual leadership by teaching a Bible Study centered on the role of disability in the relationship between Mephibosheth and David; and further, by conducting a workshop dealing with the spiritual needs of residents in nursing homes and rehabilitation centers. I also demonstrated my spiritual leadership through my preaching assignments on such topics as “Be an Overcomer,” “Encourage Yourself,” and “Let the Word Dwell Within You.”

Competency 3 Professional

My site team suggested that I work at improving my management of time with special emphasis on punctuality. I asked the site team and the chairperson to monitor my punctuality not only at the designated times of our meetings, but also the timeliness and punctuality for other assignments. They will report the result of this competency. I also asked the site team to monitor and evaluate how well our meetings were executed and whether they were well-informed about the goals and strategies of each meeting.

As the result of reflecting on this competency I became more aware of the need for punctuality, namely to start on time and to end the meeting at the designated time. In the process of preparing for our meetings, and other activities, I made certain the members of the site team knew the objectives of each meeting, the agenda and if necessary, their particular role in the activity.

CHAPTER 11
HOW TO MAKE THE CONNECTION:
STEP BY STEP DIRECTIONS FOR LIVESTREAMING A WORSHIP SERVICE

Step By Step Directions for Livestreaming a Worship Service

Getting Started

I Follow the Protocol

1. Contact the supervisory staffs of the residents in the nursing home and rehabilitation center.

2. Make certain that the requirements of the facility are followed.

3. Set up a schedule for with the supervisory staff for the live-streaming broadcast

II Equipment Needed

1. A camcorder which will be used to do the video recording

2. Two computers

   (a) One computer to be located at the church or the location of the worship service.

   (b) The second computer will be at the nursing home where the live-streaming broadcast is received.

3. The church must have a web address located on the internet.

4. A U.S.B. Cable will be used to connect the camera to the computer.

   (a). Both the church and the nursing home facility must have Wi Fi or an internet connection (video picture is transmitted through the internet)

5. Live Streaming Program such as U-stream is necessary. The program provides the necessary processing of the camera photographs so that the pictures can be delivered Other Live streaming programs are Lives stream, and Justin.[138]

III. **Making the Connection**

1. Download the Live Streaming Program into the computer which is attached to the camera.

2. Connect the computer to the camera by the U.S.B. cable.

3. Connect the camera to the internet

4. Make certain the site receiving the live streaming has the web address and is connected to the internet

5. Computer at the nursing home will go on line using the web address of the church.

6. The Live teaming video cast should be visible

[138] Streamingmedia.com, "A Buyer's Guide to Live Streaming Services."

CHAPTER 12
REFLECTING ON THE JOURNEY: LOOKING BACK AND GOING FORWARD

The Transformation

Looking back, this was an exciting journey: to watch a vision become a reality, a vision that I believe was given to me by God, reconnecting the spiritually disenfranchised to a worship experience. I can still see the parishioner in the congregation holding up the cell phone so that her husband could be connected to the worship service. I can still see the residents of the nursing home as they viewed the service for the first time. I can still see the satisfaction and real joy of the site team—particularly the technicians—who were able to work through the glitches to make this vision a reality. I want to thank God as he opened doors for us so that the vision could become a reality

This was also an opportunity for my own personal growth in terms of spiritual leadership. I learned to listen, to be patient, to wait and have confidence in the members of the team. I dropped the "do it my way" form of leadership and developed a collaborative style which, in the end, was more productive.

Going forward the live-streaming of worship services will not only enrich the religious experience of those in the nursing homes and rehabilitation centers, but it will also provide an opportunity to reconnect our sick and shut-in to our churches, some of whom have not experienced a live worship service in years. It will also provide opportunities to those who are separated from their fellowship for reasons beyond their control to reconnect.

As we enter a time when we are experiencing a virtual population explosion of the elderly, it is important that they remain connected, whether this is "body of Christ" or church fellowship or the secular. Technology offers this opportunity for them to remain connected.

Transformation in this project took place on two levels. For the first time the residents of the Silvercrest Nursing Home viewed a live-stream video cast of a worship service. This viewing occurred on Easter Sunday, Resurrection Sunday, and they subsequently viewed a second live streaming of a worship service from the Amity Baptist Church within that same month. We were in the process of making adjustments in time and scheduling when unfortunately, the recreational director with whom we were working, and who continually gave us assistance passed away; and we were asked to discontinue the live streaming until another director could be obtained. Currently, we continue our bimonthly visits to the nursing home and we will continue video streaming when a new director is selected. It was clear this was a transformational experience for the residents but because of the HIPPA regulations we could not record their responses, their excitement and interest, as they watched the live streaming of the services.

Transformation took place on a second level at the Amity Baptist Church located in Jamaica, New York, pastored by the Reverend Jeffery S. Thompson. The Amity Baptist Church was founded a hundred years ago, February 16, 1916. It will celebrate its 100^{th} birthday in May of this year. For the first time in the history of the church our worship services at the Amity Baptist Church were live-streamed to those who were sick and shut-in, as well as those who, due to circumstances beyond their control, could not be physically present at the service. Below are some of the responses of members who had

an opportunity to basically worship as the result of the live-streaming experience. For the nursing home as well as the church community of the Amity Baptist Church, the project has been a transforming experience which will be continued; a ministry which will continue to connect the sick and shut-in and those who are disconnected from the fellowship due to circumstances beyond their control to the body of Christ.

Reflections by Those Connected to Worship through the Live-Streaming Process.

Pastor

The pastor was very supportive of our efforts to connect those who were disconnected to the body of Christ through our live-streaming of our worship services. He shares his experience as he viewed the live streaming of a Sunday morning service:

> *After spending Thanksgiving away from my mother, brother and other family for the last 12 years as a result of pastoral responsibilities, I decided to take some time off to spend Thanksgiving holiday with my family in North Carolina. With my mother and other family members aging, I felt compelled to spend some quality time with them.*
>
> *On the Sunday morning after Thanksgiving, my mother and I were able to view the Amity worship service via live-stream. I used my IPad to tune into the live-stream. It was nice to be able to be a part of the worship experience, even though it was remote. Turning into the worship provided my mother an opportunity to see some Amity members she hasn't seen in recent years as she is unable to travel as much as she used to.*
>
> *While she doesn't currently possess the technology or the expertise to make it possible for her to view the live-stream, it would only take a small investment and a little training for her to do so. I see this as one of the challenges that persons, particularly elders face as the contemporary church uses more and more technology to reach those who are unable to physically be present for services.*

Shut-in Members

Eileen Mitchell is a member of Amity. She was sick and unable to attend the Sunday service. It was the 1st Sunday of the year. She wanted to be connected. She shares her experience:

A few weeks ago I had the chance to view Live Stream of our Amity service.

Not being a modern day Tech person, I was quite amazed at how great this was!

Not feeling well and upset that I was missing the first Sunday of the New Year, being able to view the service was such a wonderful thing.

I felt as if I was in service along with everyone else. I sang, I prayed, and when the Pastor preached, I said "Praise God."

Cynthia Ellington, whose mother has been a shut-in for many months shares with us how her mother enjoyed for the first time a worship service in many months as the result of viewing the live streaming of the worship service.

Habakkuk 2:2 "An the Lord answered me, and said, Write the vision, and make it plain upon tables, that he may run that readeth it."

We praise God for the anointing, wisdom, and tech-savvy vision of Rev. Audrey Brown!

Know that the live-streaming project spearheaded by Rev. Brown is very therapeutic for the sick and shut; it breaks down the walls of isolation and loneliness that so many like my Mom feel because they cannot get out of the home. It is truly a blessing that my Mom is able to attend Church services in the comfort of her bedroom by way of the outreach ministry's live-streaming produced by

Rev. Brown. My Mom has been a member of Amity Baptist Church for almost 60 years. Due to her age (95 years old) she cannot attend church as she had been accustomed to. Because of her limitations, she was becoming very depressed and lonely. The first time we setup the programming for my Mom, she was in such awe. Her first comments were: "Is that Amity? Oh, there is the Pastor. When did this happen? My Church is coming on." At this point she started clapping and shouting "Hallelujah!"

For me it is comforting to know that my Mom can still enjoy and participate in Sunday morning services. I am in Church when she is watching but the aide tells me that she sings and claps along with the service. She also enjoys watching me sing in the Choir as well as see the Church members that she has not seen in a while. When I come home from Church, she cannot wait for me to sit down before she starts telling me everything and everybody that she saw on the "computer." She does not realize that I was there so I let her continue talking. It is a joy me to that she is so happy. Amity Baptist Church praises God that we have this outreach ministry not only for the members of Amity but for anyone looking to be in Church but cannot physically be there.

LiveStreaming Keeps Me Connected

Karen Smith

Sometimes it is very tough being away from home. New environment, new faces, and new places.

In August of 2015, I found myself in Virginia for job responsibilities, away from home, friends and my church family. I was upset. How would I survive without prayer meeting, Bible Study and the word preached by my Pastor, Rev. Jeffery S. Thompson?

Then I heard of Rev. Audrey A. Brown and her innovative idea to stream the Sunday worship service. Fantastic. Here I was in Virginia and I was viewing worship services from New York. I could have a piece of home away from home. Here we are now January 2016 and I am still in Virginia—away from home, but with Rev. Brown's streaming ministry, I don't feel so far away.

I thank God for Rev. Brown and her live-streaming concept; she kept me connected to my Amity Baptist Church family.

Ingrid King

Connecting to the body of Christ a member is unable to attend Sunday services because of her job responsibilities.

Amity Baptist Church live streaming is such a blessing to my life. When I cannot physically be in the house of the Lord, I can worship and praise God wherever I am by viewing straight from my phone. I can clap my hands, stomp my feet & sing

songs unto the Lord just the same. I feel a sweet spirit just like I when thru the church doors, Thank-you Amity for making every Sunday away a better day.

For the nursing home as well as the Amity Baptist church community and the religious community at large from New York to Florida this project has been a transforming experience which will be continued; a ministry which will continue to connect the sick and shut-in and those who are disconnected from the fellowship due to circumstances beyond their control to the body of Christ.

APPENDICES

Appendix A
Demonstration Project Proposal

RECONNECTING THE SPIRITUALLY DISENFRANCHISED
MAKING ROOM AT THE KING'S TABLE

By

AUDREY BROWN

A DEMONSTRATION PROJECT

New York Theological Seminary

2015

Challenge Statement

At the Silvercrest Nursing Home and Rehabilitation Center where I serve as the Worship Leader on a bi-monthly basis, I learned that some of the residents missed receiving worship and fellowship in their home churches. Although the Nursing Home and Rehabilitation Center provide worship services and spiritual support for the residents, many of them desire to be reconnected to the worship and fellowship in their house of worship. This Demonstration Project will utilize technology to reconnect residents both visually and audibly with a worship experience.

Table of Contents

CHAPTER 1
INTRODUCTION TO THE SETTING

Silvercrest is a Nursing and Rehabilitation center comfortably nestled in a residential area of Briarwood, Queens, N.Y. Its structure looms high above the low-lying private houses adjacent to it. However, it is a short distance from Hillside Avenue and Sutphin Boulevard—very active and busy commercial streets, brimming with fast food restaurants, banks, laundry, drying cleaning stores as well as judicial courts which serve the community.

Silvercrest opened for nursing and rehabilitation services in 1989 with a mission to create a continuum of care from hospital to community. It was sponsored by Booth Memorial Medical Center and the Salvation Army. It was originally named "Booth Silvercrest." The name Booth originated from the name of the founder of the Salvation Army, General William Booth as well as the name of the Medical Center, Booth Memorial Medical Center. The name Silvercrest came from the crest of silver found on the uniform of members of the Salvation Army.

Silvercrest is a 350-bed skilled nursing facility, a member of the New York Presbyterian Health Care System affiliated with Weil Cornell Medical College. The center provides service for those who are in need of long term care, rehabilitation, ventilator and respiratory care, as well as those who would benefit from assisted living facilities. Silvercrest accepts patients 18 years and older. The median age of the population is 72 years of age; about 10 percent of the population is 55 years or younger.

Currently, Silvercrest Nursing Home and Rehabilitation Center is required to provide spiritual opportunities for its residents. We have provided a worship service on a bi-monthly basis. However, the residents have expressed a need and a desire to experience worship in a church or place of worship. This proposal would provide that opportunity.

CHAPTER 2
PRELIMINARY ANALYSIS

Challenge Statement

At the Silvercrest Nursing Home and Rehabilitation Center where I serve as the Worship Leader on a bi-monthly basis, I learned that some of the residents missed receiving worship and fellowship in their home churches. Although the Nursing Home and Rehabilitation Center provide worship services and spiritual support for the residents, many of them desire to be reconnected to the worship and fellowship in their house of worship. This Demonstration Project will utilize technology to reconnect residents both visually and audibly with a worship experience.

This proposal is based upon a need to reconnect residents of the Silvercrest Nursing Home and Rehabilitation Center to a house of worship. In conversation with residents they often feel abandoned and forgotten by the members of their original house of worship. They miss the worship service and fellowship which they were accustomed to in the past. This proposal will provide an opportunity for the residents to participate interactively—both visually and audibly—by means of the video streaming technology in weekly worship services from the 300-member Amity Baptist Church located in Jamaica, Queens, New York to the Silvercrest Nursing Home and Rehabilitation Center located in Briarwood, Queens, New York There will be no need for systemic changes in terms of how the facility normally functions. Initially the suggestion was made that the residents be transported physically to their houses of worship but this plan was revised because it would involve too many variables such as providing means of transportation and providing care of the residents while in transit.

This project will provide discussion from the following perspectives: theological and biblical; psychological and spiritual; and sociological. Biblical connections will be reviewed in terms of how the Bible views the disabled and the elderly. Questions will be viewed from the theological perspective such as how or why does God permit disability. Questions will be examined in terms of the connection between spirituality and the psychological state. The sociological aspect will be viewed through the lens of the attitudes of church congregations as they relate to the disabled and the elderly,

The practical methodology will require that the residents be evaluated before participation in the project. This will be done in collaboration with the therapeutic recreational director and a member of the site team. Information will be shared with the members of the site team in an effort to make them aware of mental disabilities which some of the residents may be experiencing. There will be equipment requirements such as a computer and a camera to telecast the service. Individuals will be trained by a member of the Site Team who is familiar with the video streaming process, so that they can assist in setting up the equipment for the video streaming. Emphasis will be placed on training young people to assist in setting up the equipment. Efforts will be made to increase awareness and interest in the proposal by setting up workshops, teaching and preaching events.

The expected outcomes are as follows: The residents in the nursing and rehabilitation center will have an opportunity to be reconnected to their houses of worship and participate in the worship and the fellowship; and the project will develop an awareness among members of the church of the need to reconnect or stay connected to church members in nursing homes and rehabilitation.

CHAPTER 3
PLAN OF IMPLEMENTATION

Goals and Strategies

Goal 1: To develop an awareness of the need to reconnect the residents of Silvercrest Nursing Home and Rehabilitation Center to their houses of worship.

Strategy 1: Develop and present a workshop in partnership with the Silvercrest Nursing Home and Rehabilitation Center to establish an awareness of the need to select appropriate nursing homes and rehabilitations centers which help residents to maintain their connection to their religious community.

Strategy 2. To conduct a Bible Study or preach a sermon to develop an awareness of the need to connect the disabled to the religious community

Strategy 3. Form a Focus Group consisting of members of the church using break out groups to discuss the issues surrounding the need to maintain a relationship with members in the nursing home and rehabilitation center

Strategy 4 Prepare "Before" and "After" Surveys to measure the impact of the above activities on the attitudes and understanding of the members of the church in developing an awareness of the need for reconnecting residents of the nursing home and rehabilitation centers to their church community.

Goal 2: Recruitment for the Implementation of the Project

Strategy 1. Create an auxiliary group of helpers to provide information to the church and the community by making announcements and sending out flyers and letters.

Strategy 2. Site members will provide training sessions for members of the focus and auxiliary groups in how to operate the video streaming technology

Goal 3: Implementation of the Project:

Strategy 1. An interactive worship experience for the members of the nursing home and rehabilitation center will be put in operation at least one Sunday in each month. Both the nursing home and the church will be provided with computers making it possible for the church and the nursing home to participate in the worship service.

Strategy 2. A time schedule for implementation will be prepared.

Strategy 3.An equipment inventory will be prepared..

Strategy 4. A "Getting Started Manual" will be prepared for distribution for those who might be interested in developing such a program

CHAPTER 4
RESEARCH QUESTIONS

Historical

How does the history of Nursing Homes and Rehabilitation Centers reflect changing attitudes toward the care of the elderly and disabled?

In the 1800s those who were elderly, disabled or required long-term nursing care were institutionalized in what were known as almshouses. Often these individuals simply required shelter and had experienced financial difficulty and were considered to be impoverished. Many of them had been abandoned by their families. The population of the almshouse consisted not only of those who had fallen on hard times such as the elderly and the disabled, but also orphan children. The almshouses contained the neediest members of the community

However, almshouses were the forerunners of nursing homes and rehabilitation centers. At the beginning of the 19th Century there were church groups and women's groups who identified with many of the occupants of almshouses because they were of the same religious and ethnic background; and they felt that they should not be housed with what they considered to be this needy element of society and they decided to establish homes for the aged. The Boston Home for Aged Women was established in 1850. The founder described the home as a haven for those who were "bone of our bone

and flesh of our flesh."[1] Prior to the establishment of the Boston Home for Aged Women, the Philadelphia Indigent Widowers' and Single Women's society established a home for the aged in 1823.

The motivation for improving the care of the elderly and the disabled was that the more worthy and disabled should not be force to live with the so-called unworthy residents of the almshouses.[2] This concern was further emphasized by requiring entering residents to pay entrance fees and have certificates which identify them as being of good character.

The living conditions for the elderly and the disabled did not improve immediately throughout the nineteenth century. The almshouses still remained as the residence mainly for the impoverished. They were places of poverty, disgrace, loneliness, humiliation, abandonment and degradation.[3] Children were sent to orphanages, the disabled remained in hospitals, and the mentally ill were sent to asylums. By 1923, 67 percent of the elderly were in almshouses—this prompted some locations to change the name of them. New York City renamed the almshouses Homes for the Aged; in Charleston, South Carolina the almshouse became the Charleston Home. The negative image of the almshouses was gradually changing.[4]

The care for the aged and the disabled began to change in the 1930s as the result of the rising number of elderly in almshouse and the passing of the Social Security Act in

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[1] Carole Haber, and Brian Gratton, *Old Age and the Search for Security: An American Social History* (Bloomington: Indiana University Press, 1994), 130.

[2] Ibid.

[3] A. Epstein, *The Challenge of the Age* (New York: Alfred A. Knopf, 1929), 218.

[4] Ibid.

1935.The Social Security Act provided for the aged who resided or live in privately funded nursing homes but not for those in almshouses. It was hoped that these pensions would make it possible for the elderly to live independently but it was discovered that many of the aged needed care and could not live independently.[5]

By the 1950s most almshouses had disappeared because they were unable to survive due to the fact that their residents no longer had financial support. Congress amended Social Security to allow residents in public nursing home facilities to receive federal support. Between 1965 and 1976 Medicare and Medicaid provided additional impetus to the growth of the nursing home industry. The number of nursing homes grew by 140 % and the number of beds increased by 302%.[6]

The long history of the evolution of the nursing home and rehabilitation centers from almshouse reflects the concern and interest in the care of the elderly and the disabled in our society.

Biblical/Theological

How does the Bible identify those who are to be classified as disabled?

The Bible identifies those who are classified as disabled. The Bible also describes the reason for their disability. The Bible views disability as a disease. Therefore those who are blind, deaf or have leprosy or who are paralyzed are considered to be disabled. From a biblical stand point there are several possible reasons why an individual may become sick and as a result be considered to be disabled. For example, Samson violated his Nazarite vows and as a result was blinded because of his disobedience (Judges16:21).

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[5] William C. Thomas, *Nursing Homes and Public Policy* (Ithaca NY: Cornell University Press, 1969), 40.

[6] Ibid.

This theme that punishment comes as a result of disobedience to God and his laws is one which runs throughout the Bible. A disability may be due to a form off testing or purification of the recipient. This is sometimes referred to as a pedagogical interpretation of suffering which may reveal itself in the form of a disability. It is said that God is teaching the individual something through his/her suffering.[7] Job was an example of this type of experience. Job was tested by sickness and misfortune which resulted in disability. The Bible also identifies a disability which provides an opportunity for what is known as charitable activity.[8] David was able to extend kindness or perform a charitable act to Mephibosheth, Saul's grandson, because of Mephibosheth's disability.

The Bible also speaks of restoration and the removal of the oppression caused by disability. The restoration is usually performed by act of healing Jesus at the very beginning of his ministry declares that his mission is one of restoration. In Luke 4: 18-19 Jesus declares:

> The spirit of the Lord anointed me to preach the good news to the poor.
> He sent me to proclaim freedom for the prisoners and the recovery of sight.
> For the blind, to release the oppressed, to proclaim the year of the Lord's favor.

However a theme still runs through the New Testament that indicates that sickness and disability are the result of sin or disobedience to the laws of God. In John 5:14 Jesus says to the disabled man he healed at the pool of Bethesda: "See, you are well again. Stop sinning or something worse will happen to you" John 5:14.

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[7] Jeffry R. Zurheide, *When Faith Is Tested* (Minneapolis: Fortress Press, 1997), Kindle location 278.

[8] Pauline A. Otieno, "Biblical and Theological Perspective on Disability," *Disability Studies Quarterly*" (2009): 3-23, http://dsq-sds.org/article/view988/1164.

In a recent effort to remove the stigma associated with disability, theologians have come to view God not as perfect or unblemished but one who himself is blemished and who has the marks of disability. Nancy Eiesland in her book *The Disabled God* [9] supports the concept recalling Jesus appearance after the resurrection where he appears to his followers with pierced hands and feet.

The Bible looks upon the elderly and aged with favor and high esteem. It grants human beings a life span of three score and ten, seventy years. However, today, with medical advances and better living conditions, according to a study of the Department of Economic and Social Affairs of the United Nations, in the year 2000 over 66 million people were eighty years of age or older; a number projected to grow to 132 million by 2020.[10] The Bible demands respect for the elderly.

> "Stand up in the presence of the aged, Thus shall you fear God" (Leviticus 19:32).
> "Honor your Father and Mother" (Deuteronomy 5:16).

The Bible views old age as an opportunity for increased opportunity and productivity and not simply a time to wait to die. Psalm 91:10 "They shall bear fruit in old age." The Bible also attributes wisdom to the aged and elderly and challenge society to make available opportunities for the elderly to share their wisdom and experience.

Social, Theological, Economic Factors

What social theological, economic, political factors influence the development of the care of the disabled and elderly?

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[9] Nancy L. Eiesland, *The Disabled God: Toward a Liberatory Theology of Disability* (Nashville: Abingdon Press, 1994).

[10] United Nations Department of Economic and Social Affairs, "The World's Women, Trends and Statistics 2000" (New York: United Nations, Statistics Division, 2000), http://unstats.un.org/unsd/publication/SeriesK/seriesk_16e.pdf, 8.

The factors which influence the image and care of the disabled and the aged are often social, ideological, economic and political. From a social perspective there has been a tendency in the past to ignore those who have a disability which tends to limit their ability to function in society. The social impact of a disability may be demonstrated in terms of how people interact with those with disabilities.[11] Often individuals feel uncomfortable and they make assumptions about those who have disabilities. They assume that they are bitter or seek sympathy for their condition. These social attitudes tend to stigmatize and marginalize those with disabilities." As a result the disabled have experienced years or decades of discrimination and exclusion.[12] An awareness developed that there was a need for greater opportunities for disabled persons to be integrated into the social community.[13]

From an ideological perspective various images have been projected which are designed to identify the disabled. The Bible addresses the disabled, the blind, the sick, the paralyzed, and the mentally ill. Although they are transformed through a healing process they are initially viewed from a negative perspective. The period of the Industrial Revolution created certain images which tended to separate what was known as the so-called "able-bodied worker" who was needed to operate complex industrial machines from those who might be considered to be disabled and non-functioning, Those who had a certain disability would be excluded and considered to be a class of industrial rejects for

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[11] Shawn Lawton Henry, "Just Ask: Integrating Accessibility Throughout Design," http://uiacess.com/accessucd/interact.html (accessed October 1, 2014).

[12] Patrick McDonnell, *Disability and Society: Ideological and Historical Dimensions* (Dublin: Blackhall Publishing, 2007), Kindle location 55.

[13] Henry, "Just Ask."

whom provisions had to be made."[14] This image would project their marginal status. This created a disability ideology that provided the basis for the institutionalization of disabled people by society. However, it also raises awareness that these ideologies were oppressive and a form of inequality. As a result there was a need for what was known as normalization[15]

From the economic perspective the disabled population was individuals who did not have the resources for self-care or management. Originally they were placed in what was known as Almshouses whose residents included not only the disabled but the impoverished as well as orphans. These residents were often labeled as defective or deviant. Religious groups drew attention to the situation and eventually received some economic support. Eventually these almshouses were transitioned into nursing homes and rehabilitation centers.

From a political perspective, political forces recognize the fact that disabled individuals needed assistance. In the United States the Social Security Act was instrumental in beginning the process of providing assistance in the form of pensions. In 1972, the Committee on Labor and Public Welfare passed the Rehabilitation Act, which extended the vocational and rehabilitations programs. It was also designed to reach out to the more severely disabled persons and provide some rehabilitation opportunities for them. Section 504 which became law indicated that no qualified handicapped individual in the United States . . . shall solely because of his/her handicap be denied participation in

[14] McDonnell, *Disability and Society,* Kindle location 320.

[15] McDonnell, *Disability and Society,* Kindle location 380.

any program receiving financial funds from the Federal government.[16] Not only in the United States but there was a global reaction to the plight of the disabled and the recognition that the disabled were entitle to some basic rights, namely a life of inclusion and equality.

[16] Richard K. Scotch, *From Good Will To Civil Rights* (Philadelphia: Temple University Press, 2001), Kindle location 540.

CHAPTER 5
EVALUATION PROCESS

The over-all evaluation of the proposal will be viewed through the lens of Peter Drucker's acronym S.M.A.R.T which is designed to evaluate qualitative demonstration action proposal. Questions which will be addressed and evaluated in surveys and questionnaires are as follows:

S. Specific: Does the proposal state specifically what is to be achieved?

M. Measurable: Is the outcome measurable?

A. Achievable: Is the outcome achievable?

R. Relevant: is the outcome applicable?

T. Timely: Can the outcome be achieved within a reasonable time-frame?

Methods of Evaluation

1. Personal interviews will be conducted by means of surveys to evaluate the impact of the interactive worship service. Personal interviews will be used to evaluate the response of those residents in the nursing home and rehabilitation center who are unable to participate in written surveys. This group will consist of eight to ten residents. The interviews will be administered by members of the Site Team and me. Expect 10% Participation.
2. A Focus Group consisting of approximately twenty members of the church will be given an opportunity to discuss their attitudes, knowledge and concerns about reconnecting residents in nursing homes and rehabilitation centers to their houses of worship. Before and After surveys will be administered by members of the Site Team to evaluate the change in attitudes, knowledge and awareness of the need. Expect 50% participation.

3. Participant Observers consisting of members of the Site Team will be asked to evaluate the process as participants in the program. They will be presented with questionnaires by me to monitor the project on an on-going basis and, as part of the impact evaluation using Peter's Drucker's acronym S.M.A.R.T., evaluate how well the process was executed to achieve the desired outcome. Expect 90% participation.

CHAPTER 6
MINISTERIAL COMPETENCIES

The Site Team met on August 3, 2014. Laura Harrison, the chairperson presided over the meeting. As the result of subsequent collaboration with the Site Team and the candidate Ministerial Competency Assessment tool was reviewed and qualifying words as seen below were assigned. In addition, they agreed through this demonstration project the candidate will work on three competencies.

Continue. This a competency in which this person excels or rates as highly. This a competency in which this person excels or satisfactory in performance;

Develop This competency which the candidate needs to hone and smooth in order to develop further;

Attention This points to an area where special attention is needed;

Start. This designates a competency for which a gift has been uncovered but is not being used and is an area to develop because the talent is latent;

Skip. This is a competency which this person for some reason should leave alone. Be sure to indicate why she or he should leave it alone;

No Basis for Assessment

Theologian

The candidate has formal training in biblical studies, knowledge of secular disciplines and the ability to make theological application. She has an understanding of her faith doctrines and traditions and desires to continue to grow theologically.

Prophetic Agent

In her preaching and teaching as well as her ministry at the nursing home and rehabilitation center the candidate demonstrates an awareness of social issues involving questions of justice and injustice and a desire and interest in providing opportunities for inclusion for those who have been marginalizes socially and spiritually.

Leader

The candidate in her role as ministerial leader of the worship team at Silvercrest Nursing Home and Rehabilitation Center demonstrates her ability to delegate responsibility to others in the worship team, to accept ideas and suggestions from others, to respect their the talents and abilities and to encourage and motivate others to do their best.

Pastoral Skills

Although the candidate is not a pastor in her role as ministerial leader of the worship team she demonstrates the ability to respect the physical, emotional and spiritual boundaries of those she ministers to at the nursing home and rehabilitation center and the ability to effectively administer to diverse groups and individuals.

Counselor

Although the candidate has been trained in counseling skills and procedures she does not engage in any active counseling. However she does maintain a demeanor of openness and a willingness to journey with others.

Administrator

The candidate has not served as an administrative capacity; therefore we have no assessment in this category

Competencies Chosen For Development

Spiritual Leader To increase engagement in spiritual disciplines and practices so that the candidate can be a more effectively communicate the spiritual presence and power of God.

Strategies

1. I will become involved in increased opportunities for spiritual disciplines such as prayer, meditation and Bible Study. I will take a course on Spiritual Formation sponsored by the Eastern Baptist Association of New York, February 23-27 in Hempstead N.Y. During the course of the year I will attempt to participate in an additional workshop/retreat involving spiritual formation. My resource will be the book, *Celebration of Discipline* by Richard J. Foster

2. I will increase my participation in enrichment spiritual activities such as retreats, workshops and conferences. I will also participate in a workshop; Women in Ministry seminar sponsored by the Eastern Baptist Association New York, February 23-27 Hempstead N.Y.

Evaluation:

1. I will maintain a log which will record my periods of pray and meditation.

2. I will share reflections and insights as the result of Bible Study with members of the Site Team and Focus Group.

3. I will prepare reflections on the impact of my spiritual activities such as retreats, workshops and conferences on me and share with others on the Site Team and Focus Group. An opportunity to share and give feedback will be given to them for reflection and evaluation.

Interpersonal Skills To increase my ability to establish cooperative relationships in my interactions with others

Strategies

1. I will develop skill in communicating constructive criticism which will maintain and enhance the self-esteem of others.

2. Opportunities and discussions will take place to discuss with the Focus Group and Site Team how we can confront and provide constructive criticism without offending. These suggestions will be charted and recorded for further references an application in interactions.

Evaluation:

1. I will prepare and participate in role-praying activities prepared by the members of the site team to evaluate my progress in developing this skill.

2. If available I will participate in a conflict management workshop. I will attend a two day workshop on basic Mediation Training March 20-22, 2015 sponsored by the New York Peace Institute. I will share these reflections with the Site Team. Resource: *Confronting Without Offending* by Deborah Smith Pegues.

Professional To increase my management of time better with a special emphasis on punctuality

Strategies:

1. I will record my arrival time for meetings and record whether or not these meetings were executed within an agreed upon time frame.

2. I will prepare timelines and flow charts for the implementation of the proposal to insure that the proposal will be implemented in a timely and organize fashion.

Evaluation:

1. My punctuality will be monitored by a member of the Site Team.

2. Organizational and time management skills will be evaluated by the Focus Group and the Site Team during the implementation of the proposal by means of

questionnaires. Resource: *Getting Things Done: Proven Methods and Tools for Time Management, Productivity and Order in Your Life* by Melanie Hutchinson

APPENDICES

Appendix A. TIMELINE

Month	Task	Tools Needed	Person Responsible
February 2015	Proposal Approved		Director Doctor W. Lundy
	Introduction of Project to church Community: Formation of a focus group	Sample: Tools: Flyers, Stationary, Postage	Me and Site Team
	Preparation of Before and After Survey		Site Team
	Setting date and time for Mar. Workshop		
March 2015	Workshop/ Seminar Speaker Director of Nursing Home	Refreshments; flyers; Surveys	
	Training Session For the use of video streaming Technology		Site Team
April 2015	Interactive Worship Service	Equipment: computers	Site Team/ Me
	Setting Up Time schedule for service		
	Providing assistance for setting up the equipment		
May 2015	Evaluation		
June 2015	Begin Writing		

Appendix B. Budget

Date	Task/Activity	Tools/Necessary	Cost Funding	Person Responsible
February 2015	Introduction of Flyers	Stationary, Project computer paper Postage	200.00	Me
March 2015	Workshop	Refreshments, Flyers Computers, Camera Gratuity For speaker	1000.00	Donation/Scholarship
April	Interactive Worship	Gas, Transportation Site Team members to And from Nursing Home To Church	50.00	Me
Total			1250.00	

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Appendix B
Bible Study and Seminars

Making Room at the King's Table

"And Mephibosheth who was crippled in both feet …ate regularly at the king's table" (NLT) II Samuel 9:13

David and Mephibosheth

2 Samuel 9:1-12

1 David asked, "Is there anyone still left of the house of Saul to whom I can show kindness for Jonathan's sake?"

2 Now there was a servant of Saul's household named Ziba. They summoned him to appear before David, and the king said to him, "Are you Ziba?"

"At your service," he replied.

3 The king asked, "Is there no one still alive from the house of Saul to whom I can show God's kindness?"

Ziba answered the king, "There is still a son of Jonathan; he is lame in both feet."

4 "Where is he?" the king asked.

Ziba answered, "He is at the house of Makir son of Ammiel in Lo Debar."

5 So King David had him brought from Lo Debar, from the house of Makir son of Ammiel.

6 When Mephibosheth son of Jonathan, the son of Saul, came to David, he bowed down to pay him honor.

David said, "Mephibosheth!"

"At your service," he replied.

7 "Don't be afraid," David said to him, "for I will surely show you kindness for the sake of your father Jonathan. I will restore to you all the land that belonged to your grandfather Saul and you will always eat at my table."

8 Mephibosheth bowed down and said, "What is your servant, that you should notice a dead dog like me?"

9 Then the king summoned Ziba, Saul's steward, and said to him, "I have given your master's grandson everything that belonged to Saul and his family.

10 You and your sons and your servants are to farm the land for him and bring in the crops, so that your master's grandson may be provided for. And Mephibosheth, grandson of your master, will always eat at my table." (Now Ziba had fifteen sons and twenty servants.)

11 Then Ziba said to the king, "Your servant will do whatever my lord the king commands his servant to do." So Mephibosheth ate at David's table like one of the king's sons.

12 Mephibosheth had a young son named Mika, and all the members of Ziba's household were servants of Mephibosheth.

13 And Mephibosheth lived in Jerusalem, because he always ate at the king's table; he was lame in both feet

Lesson Aims:

1. To develop an awareness that we need to care for the disabled physically and spiritually.

2. To understand that David had the courage to keep his promise to Jonathan to care for the cripple Mephibosheth

Background

David succeeded Saul as King of Israel

Jonathan was the son of Saul and protected David from the jealousy of Saul.

Mephibosheth was the son of Jonathan and the grandson of Saul

Ziba was a servant or steward of Saul. A steward in ancient times was an important position. He managed the day to day activities of the household of the monarch or wealthy person.

Thought Questions

1. What led Mephibosheth to refer to himself as a “dead dog”? Would you say the he had an inferiority complex because of his disability?

2. How would you say physical appearances and/or disabilities affect how we relate to others?

3. Why do you think that this story is most often used to advocate for those who have a disability or are handicap.

4. What are some of the ways we can reconnect the disabled, the sick and shut-in to the “body of Christ,” the church.

Making Room at the King's Table

"And Mephibosheth who was crippled in both feet…ate regularly at the king's table" (NLT) II Samuel 9:13

Seminar/Workshop

March 28, 2015
10AM.-12 PM
Co-coordinator
Ann Bowen

Scripture Jason Harrison Prayer….Kyle Johnson

Introduction of Ms. Simmons…..……..Rev. Audrey Brown

Question/Answer Period.

Closing Remarks……Pastor Thompson

Site Team Members:

Ann Bowen

Jason Harrison

Laura Harrison

Dr. William Harrison

Dr. Francine Hernandez

Doctoral Advisor Kyle Johnson

Ann Simmons: Therapeutic Recreational Director Silvercrest Nursing Home and Recreational Center

Rev. Jeffery S. Thompson: Pastor of the Amity Baptist Church

Anthony Tillman

Appendix C
Questionnaires

Before and After Questionnaires to develop awareness of the needs of residents of nursing and rehabilitation facilities

Before Questionnaire

1. Are you between the age of
(1) 21-34 (2) 35-45 (3) 65-80 (4) 81 & older

2. How often do you visit a nursing home or rehabilitation center
(1) always (2) sometimes (3) never

3. Do you feel something is missing if you do not attend church on a Sunday
(1) yes (2) no (3) sometimes (4) not sure

4. Nursing homes are depressing. (1) yes (2) no (3) sometimes (4) not sure

5. Residents in nursing homes are too disabled to enjoy a worship service
(1) yes (2) no (3) sometimes (4) not sure

6. A nursing home should not be responsible for the spiritual needs of its residents
(1) yes (2) no (3) sometimes (4) not sure

7. Do you feel the need to attend church every Sunday?
(1) yes (2) no (3) sometimes (4) not sure

8. Residents in nursing homes do not think about church worship services
(1) yes (2) no (3) sometimes (4) not sure

9. Residents in nursing homes do not think about church worship services.
(1) yes (2) no (3) sometimes (4) not sure

10. Part of your worship experience involves fellowship with other worshippers.
(1) yes (2) no (3) sometimes (4) not sure

Post Questionnaire

1. As the result of the Bible Study and Workshop my views and opinions about nursing homes have
   (1) remained the same (2) have changed (3) not certain of any change.

2. Residents in nursing homes can benefit from exposure to a live worship service.
   (1) yes (2) no (3) some degree (4) not sure

3. I am more aware that residents in a nursing home may feel or experience a certain amount of isolation, rejection or disconnection from their church community.
   (1) yes (2) no (3) some degree (4) not sure

4. Ms. Simmons' presentation was very helpful in helping us to become more aware of the spiritual needs of nursing home residents.
   (1) yes (2) no (3) some degree (4) not sure

5. As the result of this experience, I have become more sensitive and aware of the needs of the impaired, disabled and the handicapped.
   (1) yes (2) no (3) some degree (4) not sure

Developing Skills in Conflict Management Workshop Schedule
Saturday October 10, 2015
2:00 P.M.-4:00 P.M

Prepared by Rev. Audrey Brown
D.Min. Candidate

I. Prayer

II. Presentation…… Conflict Resolutions
Rev. Dr. Francine Hernandez

III. Role Playing ……..Scenarios

IV. Reflections…….Site Team

Evaluation

1. On a scale from 1-5 I found the workshop helpful: (1-least helpful, 5-most helpful)

1_____2._____3._____ 4._____5._____

2. Should there be more conflict management workshops?

Yes _____ No_____ Maybe_____ I don't know_____

3 How would you evaluate the candidate's skill in conflict management?

Good_____ Fair_____ Needs improvement_____

4. Suggestions: Please briefly describe suggestions for improvement.

_____
_____
_____
_____

5. Briefly describe your thoughts/ reflections concerning this workshop.

_____
_____

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